DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

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PART 10

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

TUESDAY, MAY 6, 1986.

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

HEALTH PROFESSIONS

WITNESS

ROBERT A. CAPONE, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

Mr. NATCHER. Our first witness this morning is Robert Capone. It is a pleasure to have you before the committee, and we will be pleased to hear from you.

Mr. CAPONE. Thank you, Mr. Chairman.

In the way of background, let me begin by saying that ours is a nonprofit educational association, representing the Nation's seven colleges of podiatric medicine and more than 3,300 students and residents in 165 teaching hospitals.

I represent the American Association of Podiatric Medicine.

As you know, Mr. Chairman, podiatric medicine is the medical specialty that focuses on the prevention, diagnosis and treatment of diseases and disorders affecting the human foot.

I suspect that most of us are also aware of just how important the human foot is to our daily lives. At one time or another, we have all heard those interesting facts like the feet have 52 bones, about one-fourth of all the bones in the body. Or that each day, the feet absorb about half a ton of force.

What many people do not realize, however, is that foot problems may often be an early warning sign of disorders elsewhere in the body, such has heart disease, diabetes, arthritis and musculoskeletal disorders.

From another perspective, when an individual experiences back pain, there is a good chance that the feet may be the source of the problem.

One last important fact, Mr. Chairman. As we all know, the elderly comprise the fastest-growing segment of our population. This group also happens to be the most vulnerable to foot problems.

As a matter of fact, about 95 percent of the elderly suffer from painful, often debilitating foot ailments. And according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of such ailments.

Given the demographic projections, Mr. Chairman, society can expect a tremendous increase in the incidence of foot problems in our population. The question is, will we be able to meet the challenge?

For our part, colleges of podiatric medicine are striving to prepare students for the profession. As a result of our efforts, the number of graduates has steadily increased over the past two decades.

First-year enrollments, in fact, have risen by more than 80 percent in just the last 13 years; over the same period, minority enrollments have increased 10-fold.

Despite this remarkable growth, the numbers indicate that we are barely keeping pace with the number of podiatrists that are retiring.

Consequently, this country finds itself experiencing a severe shortage of podiatrists. Today, for example, there are only 9,200 practicing podiatrists, one for every 27,000 Americans, as compared to one physician for every 600 persons.

Furthermore, the U.S. Public Health Service predicts that the current shortage will extend at least into the 1990s, when we will still be about 2,800 short of the minimum national need.

This shortage, of course, affects us all, Mr. Chairman. But the hardest hit are the elderly and those who live in inner city and rural communities. For these individuals, the shortage means that they will have to postpone or forego treatment altogether, only to face more serious and often more expensive problems in the future.

In many instances, that means society loses out in lost wages, lower tax revenues, and in higher health care costs.

Mr. Chairman, last year we appeared before this subcommittee and asked that you continue to support health professions education and training programs. You responded by doing just that, and we are most grateful.

Unfortunately, the President has once again proposed drastic reductions in this area. Once again, the Administration has painted all disciplines with the same broad brush, claiming that there is an oversupply and implying that we would be foolish to continue support.

Mr. Chairman, apart from the very real and critical shortage I have already mentioned, I would only point out that by limiting the availability of student aid monies, this budget proposal would undermine a basic tenet in our society, that of allowing every qualified person an opportunity to pursue a higher education.

In practical terms, we would be turning back the clock to a time when only the wealthy could afford to practice medicine.

To conclude, we respectfully urge you to continue to support health professions loans and we ask that you provide a minimum of $1,000,000 to continue the remote site training program in podiatric medicine.

The latter is proving to be an extremely effective program in attracting and retaining podiatric graduates in medically underserved areas.

Thank you, Mr. Chairman. I would be happy to answer any questions.

Mr. NATCHER. Mr. Capone, you have made an excellent statement. We appreciate your appearance before the committee. Thank you very much.

TUESDAY, MAY 6, 1986.

NIH, ADAMHA

WITNESS

CLARENCE PEARSON, PRESIDENT, NATIONAL CENTER FOR HEALTH EDUCATION, REPRESENTING THE LASKER FOUNDATION

Mr. NATCHER. Our next witness is Mr. Clarence Pearson. Come around, Mr. Pearson.

Mr. PEARSON. Thank you, Mr. Chairman.

[The statements of Mr. Pearson follow:]

TESTIMONY
ON BEHALF OF THE
LASKER FOUNDATION
BEFORE THE
HOUSE APPROPRIATIONS
LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION SUBCOMMITTEE

CLARENCE PEARSON

MAY 6, 1986

Mr. Chairman and members of the Committee, I am Clarence Pearson, Assistant Vice President for Health and Safety Education of the Metropolitan Life Insurance Company and volunteer President of the National Center for Health Education.

Many advocates of biomedical research and basic clinical investigation have spoken before this Committee and I concur that such research contributes greatly to the American people. However, I want to speak in behalf of health efforts that are equally important to all Americans, and that is the education and public information activities that will report to people in an understandable way the health implications of our new technologies. More specifically, I want to focus the attention of this Committee not just on health information for the American people, but for the young people. While most of us know how important basic research has been, and continues to be for our nations health, it is vital for all of us that this knowledge be disseminated in a way that can both help our young people develop positive life styles, and insure the future of our nations health.

As adults in this country seem to become more fitness conscious, all indications are that the health and fitness of America's young people are declining alarmingly. As many as one third of the children over the age of twelve have elevated cholesterol; both boys and girls are significantly fatter than their counterparts of previous years; and the number of high school students intoxicated at least once a month has more than doubled in recent years. Teenagers in the United States smoke marijuana and use other illegal drugs more than those in any other industrial nation. A study of more than four million children revealed that only one out of three could pass even the most basic standard test of fitness.

All of this occurs at a time when leaders at the national, state, and local levels frequently ignore health education, and in many cases have actually cut funding and staff support for school health programs. Based on a 1982 report from the Education Commission of the States, State policy support for health instruction for the primary grades rarely specifies the number of hours required. As a result, even when a committment is made to comprehensive school health instruction, it is generally made at a level below that prescribed by health education program developers. Many schools that offer health instruction do so on an "as needed" basis and too often the efforts are fragmented and poorly implemented. These are the facts, even though a recent national study, the School Health Evaluation, shows that positive health behavior increases in direct proportion to the amount of time and coordination devoted to health instruction.

All of us here today know that health education and public health programs can produce dramatic effects. The results of the NIH national high blood pressure education program have been impressive. This has been a classic example of translating superior research results into public information, which has gone beyond raising awareness of the dangers of high blood pressure. In the ten years from 1968 to 1978, the age adjusted death rate for all cardiovascular diseases declined by 26%, and death from hypertension declined a dramatic 53%. The high blood pressure program has taught us that such education efforts are tremendously effective, and that they succeed best when there is planned coordination and overall integration of research and health education efforts.

In the 1970's, we learned, through a national immunization campaign to reduce the incidence of childhood diseases, that success depends on a coordinated education program to support the immunization activities. Comparisons have shown a significant difference in the decrease of childhood disease where a full educational effort was underway.

In this country today, there are many single focus education programs, some of them of great value to the public. However, too often the public is bombarded with information and left to its own devices to separate the reliable from the less reliable. Too many times we confuse rather than enlighten the public with ambiguous or even conflicting statements about health behavior.

In the midst of all this, I want to make a special plea in behalf of comprehensive, planned health instruction for our children. Very recently, some disturbing reports from Cornell University Medical Center have been published regarding malnourished, underweight teenagers who are in that condition because they are dieting. A University of California study suggests that 75% of fourth grade girls in San Francisco are on weight control diets. These results do not come from school health education programs--indications are that they stem from young people's perceptions of "good health" using information they glean from general dissemination to the adult public.

Metropolitan Life and the insurance industry as a whole, have a great deal at stake in the future health of our country. We have been partners with government agencies in successful health promotion efforts and we strongly encourage broad national policy for health education. As a long range prospect we would hope to see the formation of a ~~public~~ health information institute which could integrate and thereby enhance all of the health education activities of NIH.

As a more immediate goal, I urge this Committee to support education for health, principally through the schools, and to provide funding for comprehensive health education programs for our nations youth so that they will benefit from the knowledge gained through our superb research and technology .

Thank you.

Mr. NATCHER. Thank you very much, Mr. Pearson. You have made an excellent statement. We appreciate your appearance before the committee.

TUESDAY, MAY 6, 1986.

NATIONAL CANCER INSTITUTE

WITNESS

DR. TIMOTHY R. TALBOT, ASSOCIATION OF AMERICAN CANCER INSTITUTES

Mr. NATCHER. Our next witness is Dr. Talbot.

Doctor, we are glad to have you before the committee, and we will be pleased to hear from you.

Dr. TALBOT. I am Timothy R. Talbot, President Emeritus of the Foxchase Cancer Center in Philadelphia, and former Chairman of the American Association of the Cancer Institutes, and we are also members of the Coalition that you have heard of.

We want to especially thank you for your constant and unrelenting attention, and wish you to know that we understand the enormous amount of energy that you and your committee have put into fighting to keep the biomedical research enterprise alive.

The cancer centers in this Nation have not fared well under the President's proposed budget for 1987. The last year, we have had the risk at least of having five separate hits decreasing Federal support of cancer centers.

The first was, of course, the sequestration which has already taken effect, and the second was the recision which you have not permitted. The third was the simple fact that the fiscal year 1987 proposed budget is lower than that of 1985 and 1986.

In this regard, it is understood that the fiscal year 1987 budget will cause non-competing centers to have a 5-percent reduction from commitment levels, and competing centers will be reduced by 25 percent from recommended levels.

That is another example of the inequitability, which is one of the things we worry most about. The fourth results from the proposed regulations that would cut back the indirect costs of research grants across the board for those centers that operate under the rules of Manual A-21.

Many cancer centers operate under Manual A-122, so we have, therefore, another example of gross and dangerous inequitability.

Thus, cancer centers would be hurt severely if this proposal is recommended. We strongly support the House language in the urgent supplemental appropriations bill to be considered by the House, and shortly after by the Senate, which would prevent this regulation from taking effect until September 30, 1986, giving the Congress time to initiate and establish studies to deal with the matter.

The fifth, of course, will result from the likely sequestration under the second year of Gramm-Rudman. We are taking four hits, but we will be taking them with great inequitability. My own center will not be among those hurt by the indirect costs, but I see no reason for allowing our best colleagues to be hurt.

We are also particularly upset that it has been indicated to us that there may be as many as five cancer centers which will be defunded in fiscal year 1986, because of sequestrations and other cutbacks.

There has also been added a problem by the transfer to the Office of the Assistant Secretary of Health approximately $27,000,000 for AIDS research, which is another way of wrecking what is already working by injecting micromanagement into the system.

Mr. Chairman, Dr. DeVita has done an excellent job under these tight times, allocated the dollars well, and he does not need, nor do we need micromanagement in these difficult times.

Wise judgment is more important. Finally, Mr. Chairman, we have some recommendations to make. We understand, as you have just heard, that the professionals involved in the development of a Congressionally mandated bypass budget recommended a $1,500,000,000 budget.

Obviously, there is enormous room for growth and opportunity. We do recognize, however, that the Congress has set a ceiling on the authorization of appropriations at $1,340,000,000, and we want you to know that we support that level.

There can be no sacred cows, but there should surely be no foolish sacrifices.

With regard to indirect costs, we strongly urge that this committee initiate in some fashion immediate study of this matter by independent, highly-qualified persons perhaps drawn from the feel of public policy and fiscal management who are not allied with the OMB or with the research community, to make recommendations regarding the entire subject of indirect costs.

It is our belief that A-21 and A-122 should be thrown away and simple, straightforward definitions of cost eligibility should be set forth in an uncomplicated set of easily comprehended factors with uniformity of eligibility in these categories.

No other solution can possibly be equitable or effective.

Finally, we support the Ad Hoc Coalition for Biomedical Research's suggestion of $6,070,000,000 overall for the fiscal year 1987.

Mr. Chairman, as you know, cancer centers have made a difference. They have had an impact that sparked the beginnings of a major new effort, and they will continue to do so, if they are not strangled.

Thank you, Mr. Chairman.

Mr. NATCHER. Dr. Talbot, thank you very much. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Talbot follows:]

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TESTIMONY

OF

TIMOTHY R. TALBOT, JR., M.D.

FORMER PRESIDENT AND CHAIRMAN OF THE BOARD

ASSOCIATION OF AMERICAN CANCER INSTITUTES

AND

PRESIDENT EMERITUS

FOX CHASE CANCER CENTER, PHILADELPHIA

REGARDING

FISCAL YEAR 1987 APPROPRIATIONS FOR PROGRAMS OF THE

NATIONAL CANCER INSTITUTE

BEFORE THE

HOUSE SUBCOMMITTEE ON LABOR-HHS-EDUCATION APPROPRIATIONS

REPRESENTATIVE WILLIAM NATCHER, CHAIRMAN

MAY 6, 1986

aaci association of american cancer institutes

Mr. Chairman and Members of the Committee, thank you very much for giving us the opportunity to present to you the concerns of the Association of American Cancer Institutes, which includes all of the major cancer centers in the nation.

I am Dr. Timothy R. Talbot, Jr., President Emeritus of the Fox Chase Cancer Center in Philadelphia, and former President and Chairman as well as a founding member of the AACI.

Mr. Chairman, I have appeared before you for several years, on behalf of appropriations for the National Cancer Institute in general, and the cancer centers of the nation in particular.

I am sure that you, faced with many attempts to reduce funds for the biomedical research of this nation, are as weary and frustrated at the process as are we. We deeply appreciate your constant, unrelenting attention to this matter, and wish you to know that we understand the enormous amount of energy that you and your Committee have put into fighting to keep the biomedical research enterprise of the United States moving forward as rapidly as possible.

The cancer centers of this nation have not fared well under the President's proposed budget for FY 1987.

I would like to relate to you the fact that during this year we might well have suffered five separate "hits", decreasing Federal support for research in cancer centers.

The first was the first year "sequestration" under Gramm-Rudman-Hollings, which has already taken effect, resulting in a 4.3% decrease for centers, and every other line in the budget. (The total sequestration for NCI was $53.8 million.) Some centers will suffer more than others, as the sequestration order did not take place until well into the fiscal year. Thus, we have another example of inequity.

The second was the proposed "rescission", which you have not permitted, which would have resulted in an additional $6.3 million cut from the overall NCI budget, which would also impact on cancer centers.

The third results from the FY 1987 proposed budget, which is lower than that of FY 1985 and 1986 (even after the above cuts are made for FY 1986), and would cause a further decrease in support for the centers.

In this regard, it is understood that the FY 1987 budget proposal will cause non-competing centers to have a five percent reduction from commitment levels, and competing centers will be reduced by 25% from recommended levels, compared to a 20% reduction in FY 1986. Yet another example of inequity.

This in spite of specific Senate bill report language which required that the NCI should, within budgetary constraints, fund cancer centers at the peer reviewed levels that they had been assigned (see the Senate bill report language attached to this statement).

The fourth results from the proposed regulations which would cut back the indirect costs of research grants, across the board for those centers that operate under the rules of manual A-21. Some cancer centers operate under manual A-21, while others operate under A-122. This is, therefore, yet another example of gross inequity, because of the differences resulting from A-21 rules as opposed to A-122 rules. Thus, some cancer centers would be hurt severely if this proposal is accepted. (We strongly support the House language in the urgent supplemental appropriations bill to be considered soon by the House, and shortly after by the Senate, which would prevent this regulation from taking effect until September 30, 1986, giving the Congress time to study and then to deal with the matter.)

The fifth will result from the likely sequestration under the second year of Gramm-Rudman-Hollings.

Mr. Chairman, in spite of the fact that you have turned away the Administrations's proposed rescission, we will nevertheless be taking four "hits" this year. But we will be taking them with great inequitability. That is wrong.

We are particularly upset that it has been indicated to us that there may be as many as four or five cancer centers which will be defunded in fiscal year 1986 because of the sequestrations and other cutbacks. After we have spent so much time over the years developing excellent centers, we now find that some will be "defunded". We believe that is particularly unfortunate, especially at a time when the Congress has indicated its intention that more cancer centers, not less, should be developed to serve the nation both in research and patient care.

IMPACT OF CUTS ON THE NCI

Mr. Chairman, as you know, the NCI suffered a very severe cutback, because of the sequestration order, to the tune of $53.8 million in the fiscal year 1986 budget. Happily you did not agree to a $6.8 million rescission. Additionally, budgetary confusion has been added by the transfer to the Office of the

Assistant Secretary for Health of approximately $27.2 million for AIDS research - this is another way of wrecking what is already working.

Nevertheless, when one analyzes the "bottom line" one sees the following figures emerge for NCI.

Fiscal year 1985:	$1,163,736,000
Fiscal year 1986:	$1,177,475,000
Fiscal year 1987:	$1,158,089,000

(It should be noted, Mr. Chairman, that the fiscal year 1986 figure would have been $1,170,000,000 had not the Committee fought the proposed rescission.)

Nevertheless, the result is that there is a serious drop for research in the field of cancer from fiscal year 1986 to 1987, and in fact the fiscal year 1987 figure is even below that for fiscal year 1985.

These decreases are also far more serious than would be indicated by the influence of inflation, because the essential costs of cancer research have risen at a rate that is considerably higher than that. The result is that we have fallen behind at a rate that exceeds about 11%.

We are presented with this cutback at a time when the advances in biomedical research, largely assisted by the cancer center program, have been burgeoning.

I will not go into detail on all of the advances that have been occurring. We have read with care the testimony of Dr. Vincent DeVita, Director of the National Cancer Institute. We know of the great support that you gave to Dr. DeVita in his work, and to the national biomedical community, during the time that Dr. DeVita appeared before your Committee.

RECOMMENDATIONS

We have some recommendations to make, Mr. Chairman, and they are very simple.

First, it is clear to us that the Congress of the United States has a profound respect and support for biomedical research. This was evidenced by the 10-1 vote by which the President's veto was overridden on the biomedical research authorizations bill late last year. There were authorizations of appropriations for FY 1987 in that bill which amounted to $1.34 billion. We believe that that is a sensible target arrived at over three years of careful compromises between the Senate and House on the level of cancer research funding that should be attempted.

We support the Congress wholeheartedly in this authorization of appropriations level. That is the recommendation we make to you now.

We understand that many professionals were involved in the development of the congressionally mandated "By-pass Budget", which recommends a level of $1.5 billion. We in the field believe that there is enormous room for growth, enormous opportunity available for us to advance our understanding of the diseases known as cancer, and would far prefer to support the higher budgetary level. We do recognize, however, that the Congress has set a ceiling on the authorization of appropriations at $1.34 billion, and we want you to know that we support that level. There can be no sacred cows, but there should be no foolish sacrifices.

Also, with regard to indirect costs, we recommend that this Committee urge an immediate study of the matter by an independent, highly qualified team of persons, perhaps drawn from the field of public policy and from fiscal analysis/management, who are not allied with the OMB, or with the research community, to make recommendations regarding the entire subject of indirect costs. Naturally, we would urge intimate and detailed consultation with the affected parties. Unhappily, nearly all previous proposals have come from either OMB or the research community. We know that if Circular A-21, which affects most of the cancer centers (since most are university connected), is being considered for revision, that Circular A-122 which deals with "free-standing" institutions, and which would include about 15 cancer centers, will be prepared for revision next. We hope you will consider this recommendation on indirect costs favorably. It is our belief that A-21 and A-122 should be thrown away, and that simple straightforward definitions of indirect cost eligibility should be set forth in an uncomplicated set of easily comprehended factors, with uniformity of eligibility in those categories. No other solution can be equitable or effective.

Finally, we support the Ad Hoc Coalition for Biomedical Research's suggestion of $6.07 billion overall for NIH in FY 1987.

Mr. Chairman, my final word is that cancer centers have made a difference-they have had an impact that sparked the beginnings of a major new effort. They will continue to do so if they are not strangled. And I'm sure that you know why - it is because these centers believe that it is their purpose to do so.

I will be pleased to answer any questions you may have.

SUMMARY OF FISCAL HISTORY

NATIONAL CANCER INSTITUTE

APPROPRIATIONS FOR FY 1985, 1986, 1987

	1985	1986	1987
Appropriation	$1,183,806,000	$1,258,159,000	$1,158,089,000
Enacted supplemental	3,000,000		Administration's Proposed Budget
Enacted administrative reduction		-922,000	
Sequester order		-53,868,000	
Proposed rescission		-6,800,000	

(And less transfers and administrative adjustments, including transfer in FY 1985 and FY 1986 of about $27.2 million for AIDS research transferred to the Office of the Assistant Secretary for Health.)

TOTAL OBLIGATIONS	$1,163,736,000	$1,170,475,000 (without proposed rescission - $1,177,000,000)	$1,158,089,000

TUESDAY, MAY 6, 1986.

NATIONAL CANCER INSTITUTE

WITNESS

GRACE POWERS MONACO, NATIONAL LIAISON CHAIRMAN, WASHINGTON METROPOLITAN CANDLELIGHTERS

Mr. NATCHER. Our next witness is Mrs. Grace Monaco, and we will be pleased to hear from you at this time.

Mrs. MONACO. It is a pleasure to be back testifying before you. When I started testifying before this committee on an NCI appropriation, it was 1970, the first year that the Candlelighters had begun its peer support movement.

And today, I am pleased to report to you that we are now 225 parent peer support groups in 1986. We are very pleased with the overall efforts of NCI in the area of pediatric cancer, and we have two major points to make for the record.

The first one is that we would please like you to pay attention to this disastrous reprogramming effort on the part of the OMB.

Starting with the shear, the OMB is using a programmatic approach to what NCI can do with its money, and indeed, in the past, Congress has appropriated the money and said to the NCI Director, unless we give you specific instructions, to the contrary, go forth and do the best you can with this money.

Put it where it needs to be to make a difference, where it needs to be where breakthroughs are occurring. OMB is nickel and diming them to death, and attempting to be a paper clipping board member infiltrating the cancer community, for the purpose of foolish economy and making it impossible for the Director to reallocate funds and use them most appropriately.

Please tell the OMB camel to stay out of the NCI Director's tent, and let him use the money you have indicated in the way he best sees is best appropriate.

In the other area, I want to address pediatric cancer. We are the smallest part of the cancer problem and for that reason, we are not a tremendous lobby of people all over the place who are able to amass large numbers of people marching and having busloads disgorge to make our positions known.

We are only 3 percent of the cancer problem, depending on how you look at it. Look at the record in pediatric cancer, that is the area in which the greatest strides in concurring the cancer problem have occurred, and the strides that are being applied to make a difference in adult cancer patients.

We were the pioneers in the area of combined chemotherapy for treatment, and now in a new area, an area that will really make the difference in what happens in adult cancer, and that is the whole idea and area of genetics, chromosome translocations, finding those little switches, if we learn to reprogram them, turn them around, are going to change the cancer cells back into what they should be, or permit us to tailor the therapies to deal with those cancers more effectively.

One example, in the National Institutes of Health in the clinical center in the intramural program, they have lately discovered some of these switches. As a result of that, in selective productive therapies, research in proto-oncogene expression has revealed the genetic similarities between neuroepithelioma and Ewings sarcoma.

Prior to this discovery, children with neuroepithelioma were treated under a nueroblastoma protocol. Treatment under Ewings sarcoma protocol has led to superior treatment results.

The difference is between a 90-percent negligible response rate and now a 60-percent projected cure rate. There is every reason to believe what we have learned in pediatric cancer can soon be applied to the colon cancer cases and the lung cancer cases, so we can start to see initial inroads into the survivorship into the area of cancer.

Why do I make this point? I make the point because our childhood cancer programs, although they get the best priorities from the peer review committees, are the ones that fall under the ax the most quickly.

Children are cute and sexy and a lot of people believe you can rise the money on the streets if you don't get it from the Federal Government.

That is not the case, nor should we be directed to do that, and my suggestion and request to you is to please, when you are looking at the budget, fully fund the areas that deal with intramural research in pediatric cancer, the clinical cooperative group programs, the clinical center programs that have made a tremendous difference in the way we are able to discover new inroads in cancer, and to discover ways in which we can deliver cancer more effectively.

I thank you very much for all your support in the past, Mr. Chairman. I would be happy to respond to any questions, and I hope, God willing, I will see you and me back here again next year.

Mr. NATCHER. We appreciate your appearance at this time before the committee. You have given us a good statement, and we appreciate it.

[The statement of Mrs. Monaco follows:]

STATEMENT

BY

GRACE POWERS MONACO, J.D.
NATIONAL LIAISON CHAIRMAN
CANDLELIGHTERS (PARENTS OF CHILDREN WITH CANCER)

BEFORE THE

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION SUBCOMMITTEE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON APPROPRIATIONS

APRIL 24, 1986, 3:55 P.M.

Mr. Chairman and Members of the Committee:

My name is Grace Powers Monaco. I am National Liaison Chairman of the Metropolitan Washington Area Candlelighters. This association serves as the legislative arm of an international volunteer coalition of 225 groups of parents whose children have or have had cancer in 50 states and Australia, Canada, Chile, Denmark, England, Finland, France, Germany, Greece, Guatemala, Holland, India, Indonesia, Ireland, Israel, Italy, Mexico, New Zealand, Sweden, South Africa, Spain and East Africa.

When I first testified before this Committee in 1970 this nation was in a crisis point in federal cancer research funding. At that time we were only projecting the ability to fund research project grants at 50%. Today in 1986, that funding rate for peer reviewed and ranked research grants is only 27%. With the ripple effect, this Committee can anticipate how far the proposed budget will set back cancer research and its application in treatment and prevention.

This dismal as the prospect of such diminished research grant funding is made even more dismal by a hooker thrown at National Institues of Health by Office of Managment and Budget fiat regarding the apportionment process.

Until 1985, OMB distributed or apportioned funds appropriated by Congress directly to each of the NIH Institutes. Under this approach the Directors of the Institutes had the flexibility to make do within the budgetary restraints by shifting funds among program mechanisms to accomodate promising or new avenues of opportunity.

This is no longer possible. OMB now apportions all 16 NIH appropriations to NIH as a whole and specifies the amounts to be distributed by time period, by major categories of NIH expenditure or mechanism, such as grant, contract, centers etc. and by numbers of awards within selected categories.

The Congress tells NCI what funds it will get, makes a few suggestions on special areas of emphasis if needed and say--get on with it, best good use of your countries money. OMB says you are bound by every nitpicking line in your proposed budget, if you find a way to cut A, your can't shift it to immediately start on implementing research in new breakthrough B, you have to give us that money back. Good for their bottom line, bad for the patients looking for survival from cancer.

Please tell OMB to get their noses out of the tent and give the Directors the flexibility to make the best use of our money as their scientific knowledge dictates.

Dr. De Vita's testimony before this Committee well portrayed the exciting scientific times ahead for cancer research and treatment. He omitted reference however to the most important laboratory for the discovery, development and implementation of curative cancer therapy - the pediatric cancer patient.

At the President's Cancer Panel meeting in Memphis on April 11 at St. Jude Children's Research Hospital which addressed"the molecular characterization of childhood cancers and its application to innovative approaches to cancer therapy" Director De Vita remedied that omission. Dr.De Vita stated that pediatric researchers had initiated work on the cytogenetic problems in cancer in an orderly fashion ahead of their peers working in adult cancer. This comes as no surprise.

It was this population that was the guinea pig for the combination therapies that are now translated into increasing cure and survival rates in adults. A study by Dr. Robert W. Miller and Frank W. McKay published in the Journal of the American Medical Association * tracked deaths from cancer among children under age 15 from 1950 to 1979. It showed in that period:

80% fewer deaths from Hodgkin's disease, a type of blood cell cancer;

68% fewer deaths from kidney cancer;

50% fewer deaths from leukemia and bone cancer;

32% fewer deaths from other immune system cancers; and

31% fewer deaths from all other cancers.

1970 survival rate overall for childhood cancer was 39%. Now over 54% are surviving their disease.**

It is this group that now serves as the guinea pigs for progress in fine tuning treatment programs and in attacking resistant cancers and residual tumors. Our children are the tabula rosa of cancer

* JAMA: 251(12) 156-70) March 1984

** American Cancer Society Statistics 1984 research unsullied by the bad habits and exposures of adult life, giving a clear view to the genetic and chromosomal contributors to failures or success.

The magnificient work of Dr. Janet Rowley and colleagues presented at the President's Cancer Panel has trageted chromosomal defects and changes in Acute nonlymphocytic leukemia. Due to this ground breaking work knowledge of where and why chromosomal translocations and the like take place, what they mean and what they do is laying the groundwork to target defective genes in treatment and spare healthy genes.

In childhood neuroblastoma, identification of c-myc gene amplification helps target poor prognosis cancers and single those out for more aggressive treatment as well as pick up the disease progress earlier for special attention.

This hallmark work will increase our knowledge of who may have predispositions to certain cancer to permit earlier diagnosis, treatment and potentially prevention.

Further, in selective productive therapies, research in proto-oncogene expression has revealed the genetic similarities bewteen neuroepithelioma and Ewings sarcoma. Prior to this discovery children with neuroepithelioma were treated under a neuroblastoma protocol. Treatment under Ewings sarcoma protocol has lead to superior treatment results. Before treatment substitution neuorepithelioma was considered an usually lethal condition. Now these children are enjoying a 93% response rate and a 60% projected cure rate.

The cyto-genetic characterization of tumors is in its infancy but it is the key to matching treatment to disease with the best hope of success. Once again, our children are the laboratory and in collegiality these pediatric cancer researchers are sharing skills, probes, tumors across institutional lines to a common purpose.

It is anticipated that the work on proto-oncogenes which has gone forward in our unique pediatric cancer projects will soon be applied to identify treatable subsets of lung and colon cancer hitherto impossible.

From basic research to bedside to long term follow-up, our children are the unique laboratory for pediatric cancer centers of excellence, joined through cooperative clinical trial relationships including the pace setting efforts of the National Cancer Institute's intramural and clinical center programs in pediatric cancer. The efforts of these professionals are enhanced by the patient and family coping and education materials conceived by the Office of Cancer Communications.

The proposed budget would compromise the continued effectiveness of all these programs which have spelled the difference between cure and merely long term survival for many of our children.

Under the proposed budget:

Our clinical cooperative programs, pediatric and adult would be reduced 20%,

Our centers programs 25% and

The functions of the Office of Cancer Communications to directly translate survival skills during cancer to the patient and family populations would be amputated.

Our please to this Committee is:

To fully fund the cooperative and centers programs,at the level that peer review has found warranted,

To retain the financial base to permit Office of Cancer Communications to do the job needed and

To fully fund and support NCI's intramural research and trial activities.

Further, fully fund P01's the mechanism to translate research advances to the bedside.

Cooperative Clinical Research should be fully funded at $50,204,000

National Cancer Institute Intramural program should be fully funded at $194,847,000

Clinical Centers programs should be funded at $135,627,000

Office of Cancer Communications should be fully funded at $900,000.

Cancer biology should be fully funded at $258,686

Pre-Clinical Research should be fully funded at $176,801

Clinical treatment research should be fully funded at $180,807.

Mr. Chairman, Members of the Committee, on behalf of all these parents across the country, I should like again to commend the Chairman and the Members of the Committee for this many efforts and their understanding of our problems. Your dedication to the cause, the cure and the prevention of cancer encourages us to face the future with a greater degree of hope and peace of mind. Those of us who have lost children are grateful that your efforts to adequately fund the cancer research will be a memorial to them. And, those of us whose children are under treatment are grateful for the hope which research gives us in maintaining their well-being.

We gratefully acknowledge the part this Committee has played in this effort to conquer this dreaded disease. Thank you for permitting us to appear before you.

TUESDAY, MAY 6, 1986.

NIOSH

WITNESS

DR. NORTON NELSON, ASSOCIATION OF ENVIRONMENTAL HEALTH SCIENCE CENTERS

Mr. NATCHER. Our next witness is Dr. Norton Nelson. It is a pleasure to have you back before the committee, and we will be pleased to hear from you.

Mr. NELSON. I am honored to be here, and I must bring first an apology from my predecessor, Dr. Arthur Upton, who was unable to appear today, and asked me to appear for him, which I am delighted to do.

I am appearing on behalf of the Association of Environmental Health Science Centers. These are specialized research and teaching centers aimed at improving our knowledge to the chemical, physical factors, teaching experts in the field who then make their careers in government, in universities, and in industry.

These centers number a total of 15. They appear in the most distinguished universities in the country. It is a small group basically, but it is a cadre of experts whose career is permitted through the presence of these centers, and can convert their entire research and teaching activity to these concerns.

They are understandably a group of respected experts in the field, highly sought after for advice by national agencies, local agencies and in many other areas.

I might just say on Friday night, as Dr. Upton asked me to appear before him, he was on the phone with the State Health Commissioner, asking him to assemble a team to go to Kennedy to check out the returnees from the Russian tour visit.

Thanks to the center activity, we have been able to sustain such resources during some dark days for such activities elsewhere.

Our center is not unique in this. Centers throughout the country are in a position of providing guidance to agencies at all levels as well as conducting basic research, which is improving our knowledge.

Your time is short. I am paraphrasing my statement, which has been submitted for the record. I think I will turn to a bit of historical information that I would like to read. My colleague, when he learned I would be here today, put before me a hearing record in 1960, when I appeared before the Mr. Fogarty, your predecessor, sir.

He asked me if I would care to put before you a comment that appears there. The major source of our present interest in environmental health is the very machinery of our present-day civilization, and it is appropriate to focus primary attention on the fact that technical advances bring with them threats and equally, the obligation to develop the confidence to insure, that the cost does not help what you gain.

The Nation very early recognized this, and Mr. Fogarty contributed to that recognition, and give what he saw as sparks of intellectual commitment, professional dedication in an activity that at that time was very little understood, as grown and provided the basis for these continuing centers, for teaching and research.

Sometimes it is thought our activities are there to dig out nasty threats to health, this is not the case at all. If they are real, we are there to dig them out.

If they are unreal, it is our threat to permit a level of response that is appropriate to the concern, but not excessive. We are—your committee has been very helpful to the centers, and we are very grateful for that.

We are concerned in these present difficult times that impetus may be lost, and that gains made will be sacrificed.

Very simply, sir, we are here to hope that we will have again your backing to maintain this competence within the Nation.

Mr. NATCHER. Dr. Nelson, thank you very much. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Nelson follows:]

Testimony before the House Subcommittee on Labor, Health and Human Services and Education and Related Agencies

May 6, 1986

Norton Nelson
Institute of Environmental Medicine
New York University Medical Center
New York, New York 10016

My name is Norton Nelson. I am Professor of Environmental Medicine, in the Institute of Environmental Medicine, New York University Medical Center. I was Chairman of the Department and Director of the Institute of Environmental Medicine for some 26 years, a position which I relinquished some five years ago. I have been succeeded by Dr. Arthur Upton, former Director of the National Cancer Institute, who unfortunately is unable to appear today. I remain full time in teaching and research in the Institute.

My testimony today is submitted on behalf of the Association of University Environmental Health Science Centers. This is an organization representing 15 NIEHS-supported research Centers throughout the U.S., five of which specifically focus on the relationship of health to the quality of marine and fresh water. The Centers are situated at Duke University, Harvard University, Johns Hopkins University, Massachusetts Institute of Technology, Mount Desert Island Biological Laboratory, Mount Sinai School of Medicine, New York University, Oregon State University, University of California at Berkeley, University of Cincinnati, University of Rochester, University of Washington, University of Wisconsin at Milwaukee, and Vanderbilt University.

The mission of the Centers is essentially threefold; namely: 1) research aimed at the prevention or control of environmentally related diseases, 2) training of experts in the environmental health sciences, and 3) relevant technical assistance to the government and the private sector.

Because of the accelerating impacts of technology on health, the mission of the Centers is more urgent today than ever before. For example, the number of mass poisonings from accidental release or misuse of toxic substances is increasing e.g., 3,000-4,000 victims were poisoned by the grain fungicide chlorobenzene in Turkey in the 1950s; 10,000 victims were poisoned by cresyl phosphate-contaminated cooking oil in Morocco in 1959; 50,000 victims were poisoned by methyl mercury fungicide-impregnated grain in Iraq in 1971; 7,500 victims were poisoned by the pesticide malathion in Pakistan in 1976; 12,600 victims were poisoned by chemically contaminated cooking oil in Spain in 1981; tens of thousands victims were poisoned by methyl isocyanate (MIC) in Bhopal in 1984; and 9,000 victims currently die each year from pesticide poisoning in various countries of the world. The aforementioned examples are but a few of the many thousands of injuries by toxic substances which are on record. Dramatic as they are, they fail to convey the full impact of the problem. Of the millions of chemicals that exist in nature, or of the thousands that are produced commercially, fewer than one percent have been tested for toxicity. As a result, the biological activity of most substances is unknown. After the accidental release of MIC at Bhopal, for example, there was insufficient information about the substance to enable physicians to predict its long-term effects or to treat the surviving victims in ways that would assuredly prevent them from permanent suffering harm in the form of blindness, chronic obstructive pulmonary disease, cancer, or other complications. Since the effects of many other toxic substances also are unknown, many cases of environmentally related disease undoubtedly fail to be recognized as such. Thus, many cases of cancer in the general population resulting from exposure to asbestos, arsenic, radon, cigarette smoke, or other environmental agents are never linked to their actual causes. Similarly, impairments in intelligence and stature caused by excessive exposure to lead during childhood. and thus preventable, have not until recently been recognized as such. The extent to which the health of a growing number of U.S. communities is be jeopardized by chemical contamination of drinking water supplies is only now beginning to be appreciated.

Because of the complexity of these problems and their far-reaching environmental, economic, and socio-political implications, it is gratifying that the NIEHS has developed a strong national program in environmental health. The NIEHS-supported Centers have a key role to play in the program, by enlisting the full range of disciplines and talents needed. By tapping such intellectual resources in the universities where they exist, the Centers greatly multiply the productivity of their own research funds. The Centers also form an important network of collaborating research groups which spans the entire globe. Through the resulting multidisciplinary and multi-institutional collaboration, the latest developments in all relevant branches of science are rapidly exploited.

As a training ground for future specialists in environmental health, the Centers play another uniquely important role. The field of environmental health is new enough so that few well developed training programs exist outside the Centers. As a result, government, industry, and academia look to the Centers as sources of appropriately trained specialists. The demand for such experts, which is now at an all time high, will be even greater tomorrow.

The Centers also constitute uniquely valuable repositories of expertise for the nation and for their respective communities. Each Center provides knowledgeable personnel and advisors to government, industry, labor, and society at large. The Centers are thus called upon continually to help with environmental emergencies. Examples of the problems that our Center at New York University have been asked to help with include, among others: 1) development of rehabilitation and habitability criteria for a New York State office building contaminated with PCB's and dioxin as the result of a transformer fire; 2) assessment of the health-hazards associated with elevated indoor levels of radon gas in homes in Pennsylvania, New York, and New Jersey; 3) evaluation of the public health implications of elevated plutonium concentrations in a sample of New York City drinking water; 4) development of habitability criteria for homes at Love Canal; 5) assessment of the health implications of the air pollutants projected to be emitted by a proposed New York City municipal solid-waste incinerator; 6) evaluation of the long-term health effects of exposure to radiation in U.S. atomic veterans; 7) assessment of the long-term health effects of exposure to agent orange in Viet Nam veterans; 8) evaluation of the health implications of perchlorethylene contamination of the municipal water supply in a New England town; 9) analysis of the potential health hazards to school children of exposure to asbestos in school rooms; 10) assessment of the health-hazards of chemicals released from a toxic waste dump in California; 11) evaluation of the public health implications of ambient levels of ozone, sulfur dioxide, benzene, gasoline vapor, formaldehyde, acid aerosol, and other air pollutants; and 12) assistance in examining Americans who were visiting the USSR in the vicinity of Kiev at the time of the reactor accident at Chernobyl, for evidence of internal radioactive contamination.

As the world's leader in technological innovation, the U.S. can be justifiably proud of its leadership in environmental health; however, its task has barely begun. To cope with the entire spectrum of environmentally-related diseases will require further and sustained effort. NIEHS has developed a research program for this purpose which must not be curtailed. The cuts in the 1987 budget that have been contemplated would seriously set back efforts to deal with the urgent problems mentioned above.

In closing, Mr. Chairman, I would like to thank the Committee for the privilege of testifying on behalf of the environmental health science research community. Your consideration is deeply appreciated.

TUESDAY, MAY 6, 1986.

CORPORATION FOR PUBLIC BROADCASTING

WITNESS

DOUGLAS J. BENNET, PRESIDENT, NATIONAL PUBLIC RADIO

Mr. NATCHER. Our next witness is Mr. Douglas J. Bennet. Come around, Mr. Bennet.

Mr. BENNET. Mr. Chairman, it is a pleasure to be here. I have a prepared statement to submit for the record.

I am Doug Bennet, President of National Public Radio, and represent 331 public radio stations around the country. I have some with what I think is a very positive report on a matter that I know the committee has given very close attention to in the past.

National Public Radio is in good shape. The debt that we incurred to the Corporation for Public Broadcasting will be paid by this October, on schedule. Of the $7,000,000 we borrowed, only $250,000 remains to be paid.

Membership is up 8 percent, and our audience is up 12 percent.

In the programming area, All Things Considered, a morning edition, I think they are stronger than they were a year ago. We have got a new show of Weekend Edition on Saturday mornings.

Public radio stations around the country have continued to serve their community. WHYY, gavel-to-gavel coverage of the MOVE investigation in Philadelphia.

I would be happy to go into as much detail as the committee wishes, but the report is good. We have undertaken a major structural change in public radio. In the past, funding Congress has approved has gone to the Corporation for Public Broadcasting, and the other large portion has gone to the stations in the form of grants, for reasons that we can discuss, but basically, to eliminate ambiguities about accountability that we are sort of limiting everybody's ability to function.

We have rearranged things so the preponderance of the money will be directly to the stations in the future, and NPR will be supported by those stations entirely.

We are confident the basic service will continue. There are obvious difficulties with any kind of institutional change like this, but having just come back from the public radio conference in San Diego, I am confident we can deal with this new institutional structure in a way that will bring greater vitality to public radio.

Now, we are asking the committee for an appropriation at the level of $238,000,000, in 1989, for public broadcasting. I am happy to be able to come before you with a signed authorization this year, which has not been the case frequently in the past.

The amount of increase, 1989 over 1988, for radio would be 11 percent, $5,400,000. We expect an increase in the number of stations of 5 to 6 percent, so a net increase that is at or approximately the rate of inflation.

You have to answer questions from your colleagues daily, I know, about why should there be any increase at all. The two answers for public broadcasting, first the uniqueness of the service.

Your constituents will tell you what they tell us, which is that it is a lifeline. People use that word with me all the time.

The second is the multiplier effect that this Federal investment has on the system. We raise from State and local sources and from audiences, underwriters and foundation grants $6 to $7 for every dollar the Federal Government puts into public broadcasting.

I think that multiplier effect is clearly associated with the Federal contribution, the Federal affirmation, makes this a very good investment.

Thank you very much, Mr. Chairman.

Mr. NATCHER. Mr. Bennet, thank you, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Mr. Bennet follows:]

Testimony of

Douglas J. Bennet

President

National Public Radio

Before the

U. S. House of Representatives

Labor, HHS and Education Subcommittee

Committee on Appropriations

April 23, 1986

Mr. Chairman, I am delighted to be here to testify, on behalf of National Public Radio and its more than 300 member stations, in support of funding for the Corporation for Public Broadcasting. As you know, because of the forward funding mechanism Congress has put in place for public broadcasting, we are discussing the FY 1989 CPB appropriation.

I am especially pleased to be seeking funding in the proper sequence. For the past two years this Subcommittee has funded public broadcasting without an authorization bill in place. I know this is not the way you prefer to do business, Mr. Chairman, and we are grateful for your support as well as your indulgence.

This year we do come before you with an authorization bill in place. On April 7 the President signed H.R. 3128, the Consolidated Omnibus Budget Reconciliation Bill, which includes funding levels for CPB through 1990. This legislation, P.L. 99-272, authorizes CPB at $238 million for FY 1989, which is the funding level we seek today.

I am also happy to report a number of positive developments at National Public Radio to the Committee. These include new programming initiatives -- the successful launching of WEEKEND EDITION, the Saturday version of NPR's award-winning news program MORNING EDITION; the development of an exciting new concert music and arts information program scheduled to debut this fall -- as well as substantial progress in returning NPR to sound financial footing.

NPR Regains Sound Financial Footing

NPR ended fiscal year 1985 with a positive fund balance of a little over $1 million. The $6.9 million debt to CPB, incurred at the time of our 1983 financial crisis, will be repaid ahead of schedule at the end of this fiscal year. NPR made a $1.5 million payment to CPB at the end of March, leaving an outstanding balance of only $226,000. We are proud of our repayment record, made possible by our member stations assuming the responsibility for repaying the CPB loan, and the fact that no federal funds were used to restore NPR's financial health.

In addition to assuming responsibility for repaying the CPB loan, our member stations have also registered other impressive gains. Now numbering 331, up from 303 at the end of fiscal year 1984, their increased number and listenership helped boost NPR's audience by 12% in FY 1985.

After 15 years of growth and development, a number of stations now produce local programming of national quality, which is distributed across the country by NPR through the public radio satellite interconnection system. This is especially true for arts and performance programming. MARIAN MCPARTLAND'S PIANO JAZZ, produced by the South Carolina Educational Radio Network; A MUSICAL OFFERING, the classical music series produced by WBUR in Boston, and folk programs produced by WCMU, Mt. Pleasant Michigan; WBEZ, Chicago, and West Virginia Public Radio are just a few examples of such programs.

It is this partnership between strong national programming and strong community involvement and support which gives public radio its special character.

Quality National Programming and Strong Local Involvement are NPR Hallmarks

National Public Radio is known for its quality program content. During FY 1985, NPR programs were honored with 20 broadcast awards. Nine of the winners aired on ALL THINGS CONSIDERED and 5 on MORNING EDITION, with the others divided among other offerings.

News and information programs continue to lead the system in listenership. While NPR's audience grew 12% overall last year, the audience for MORNING EDITION grew a spectacular 32%.

But quality national programming would be meaningless without local stations to carry it into every state in the country. We are proud of the record of increased audience and local support established by our member stations. Subscriber income for public radio grew by 21% between FY 1983 and FY 1984, the most recent year for which figures are available. This significant increase in listener support reflects the special relationship public radio stations have with their listeners, and with their communities.

Each radio station builds this relationship in its own way. It might be a significant effort to support the local arts community, as WFCR, Amherst, Massachusetts does by sponsoring the New England Arts Biennial, or WUFT, Gainesville, Florida, does by organizing an open air concert on the Fourth of July. It might be WKYU, Bowling, Green, Kentucky, bringing National Press Club luncheon addresses to the Cumberland area of Kentucky. It might be WHYY in Philadelphia giving live coverage to the hearings on the handling of the confrontation with the MOVE group and destruction of a neighborhood.

The evidence of public radio's contribution to enhanced quality of life and service to the community is in every station manager's files -- the letter from the local symphony conductor, or museum director, citing the increase in attendance after his public radio station noted an event. The public service commendation from the governor for staying on the air and giving up-to-the-minute hurricane or flood bulletins. All these things build the kind of community support that leads people to dig into their pockets and send contributions for a service they can receive for free.

New Business Plan Reflects Growing Maturity of National Public Radio System

The increasing strength of local stations has led the NPR membership to develop a bold new business plan. The plan, which has CPB's approval, will put all but a small percentage of radio funds directly into the hands of the stations. In FY

1987, for example, the Public Broadcasting Act formula gives $45 million of the $200 million CPB appropriation to the public radio system. Of that $45 million, all but $3.1 million will go directly to stations, which may use these increased funds to produce their own programming, support NPR, and acquire programming from other sources.

Although the plan is not without risk, we believe it will ultimately benefit listeners, because a majority of radio funds will be spent at the discretion of the local licensee, in ways which he or she believes best serve the needs of his community.

We also believe this system will continue to provide the "critical mass" of resources necessary to continue NPR's hallmark national programming. In fact, at the most recent NPR Board Meeting which set FY 1987 budget priorities, stations indicated that maintaining the current service level was critical, and also recommended expanding news and information programming to seven days a week, in both mornings and afternoons.

However, the new business plan is not on automatic pilot. It will be carefully evaluated each year both by the

Corporation for Public Broadcasting and by us, to make sure it is working within the confines of the Public Broadcasting Act.

Importance of Federal Commitment

With increasing station membership and listener support, one might ask whether there continues to be a role for federal funding in public radio. There most certainly is.

Every federal dollar appropriated to public broadcasting leverages $6-7 in non-federal income. This record is among the best of any federal program. Over and over again station managers tell us of the importance of federal money to their fundraising efforts. Station WEVO in Concord, New Hampshire, has one of the highest percentages of listener support in the system -- 15% of its listeners are members. Yet station manager Marjon van den Bosch says this outstanding record of financial support is definitely the result of a public/private partnership. "Corporate and foundation funders like to know that their gift has an impact on the amount of federal funding. We use CPB Community Service Grant funds almost as a challenge grant," she notes.

Beyond their role as a proven catalyst in building other support, federal funds provide relatively unrestricted funds that allow for long-term program development and planning.

The system could not support program development without the help of CPB funding. CPB money is the research and development money of public broadcasting. It provides the seed money necessary for the developmental stages of program production. Typically, it takes 8 months to a year or more to bring a program idea to the point where it can be taken to outside funders. The new concert music series, which we expect to be very popular with both stations and underwriters, has been in development for a full year.

Most corporate and individual donors want their gift tied to a proven product. They are not very interested in underwriting a new venture that may not be aired for a year or more. Commercial broadcasting also cannot risk funds for experimentation and new program production. Often if the public broadcasting system doesn't develop new program concepts, it just won't get done. The forward funding concept helps accomplish this objective, and is also of great importance to insulating programming from political influence.

Taken together, all this means that the Administration's expired CPB recission requests of $14 million in FY 1987 and $44 million in FY 1988, and sharply reduced outyear funding levels, would simply be devastating. There is no doubt that it would dry up the programming pipeline and force stations off the air.

New reductions would seriously erode the financial foundation of a national telecommunications system which currently generates approximately $800 million in non-federal dollars. For radio, the proposed FY 1987 recission would have meant a $3.2 million reduction in support for national program production and stations at a time when the number of stations eligible to receive CPB financial assistance is growing. The result would have been little or no growth in funds available for local station operations.

Reductions would also seriously impair one of the greatest assets of the public radio system -- its ability to serve as a medium by which local communities help themselves.

Under the new federal budget realities, more and more services will have to be provided for our citizens at the local level. Public radio makes a unique contribution in helping local communities do just that.

Summary

In closing, I would just like to say a few words in reference to funding for public broadcasting in the climate of fiscal constraint which we all face.

I am aware of the budget pressures under which the Committee is operating. In scrutinizing federal spending to reduce the federal budget deficit, it is clearly a time for choosing. Congress must exercise its authority to examine each program on its merits.

Corporation for Public Broadcasting appropriations benefit every state in the nation. These funds play a significant role in enriching the lives of Americans, whether they live in Boston, Massachusetts; Rhineland, Wisconsin; or Dillingham, Alaska. But such contributions are sometimes difficult to measure. How do you measure the value of stimulating the imagination of a young listener to "see" radio drama pictures? How do you measure the tolerance for ethnic differences which listening to folk music can bring? How do you measure the worth of bringing the finest in arts and performance programming to the elderly who cannot afford to attend concerts, or to citizens of towns and villages located far from cultural centers?

Public radio helps provide these benefits -- benefits to our country, as well as to our listeners.

The United States has many needs. We also have many resources. A measure of our greatness as a nation can be found in the careful balancing of the distribution of those resources. NPR believes that funding at the highest possible level for public broadcasting belongs in that balance

TUESDAY, MAY 6, 1986.

CORPORATION FOR PUBLIC BROADCASTING

WITNESSES

RICHARD OTTINGER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

PETER FANNON, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

Mr. NATCHER. Our next witness is Dr. Ottinger, and Mr. Peter Fannon.

Mr. FANNON. Thank you, Mr. Chairman, good morning.

We appreciate the chance to be with you today and to let you know about the progress we have made based on the support that your committee has given public broadcasting over the last few years, and to ask for your continued support.

In 1989, Mr. Chairman, we respectfully request your committee to recommend a level of $238,000,000 for the Corporation for Public Broadcasting. This level is the full authorized amount, just adopted in the new reauthorization package for CPB, but is not, however, the total amount truly needed to retain current service activities. In fact, if that level were appropriated, it would be $288,000,000.

At this point, Mr. Chairman, public broadcasting is in the midst of trying to rebuild from the reduced levels of the not-distant past in trying to apply new resources for future work.

Public broadcasting is a cooperative effort involving the joint activities of public television and radio stations around the country working with the Corporation itself.

We have taken the appropriations that the Congress has given in 1987 and 1988, and applied them to new program ventures and committed those funds under the advanced funding principle, which the Congress has adopted for public broadcasting, and we expect to be able to refill the program pipeline which had been running dry, based on the loss of cash and in-kind support over the last several years.

We are beginning to reach a position where public broadcasting once again looks forward to trying to meet some of the demands on it, special demands, that no others in the media can provide.

The services in education, information, children's activities, science and the like. At this stage, public broadcasting serves well over 100,000,000 people per week, including 19,000,000 school children day in and day out.

With me, Mr. Chairman, is the new Chairman of the National Association of Public Television Stations, Dr. Richard Ottinger, and I will ask him now to speak.

Mr. NATCHER. Thank you very much.

Mr. OTTINGER. I succeed a gentleman who I know did an excellent job for this committee over the years, Mr. David Ives, and I promised to fulfill that promise to this committee.

Since I am newly elected to this position, I could speak better about the Georgia system.

First, on behalf of all public television stations and public radio stations in the country, I know I am speaking for them, extending

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our thanks to you personally, and to the subcommittee for helping to build up the funding back to the levels that can help to sustain public broadcasting in the United States, because this forward funding concept is most important to the local stations, as well as the national level.

For every dollar provided here, that becomes the buttress for $7 to $10 of other sources. In Georgia, we operate a nine-station, 11-translator public television network serving 96 percent of the peoples and schools.

Our major mission in Georgia is that of education, and education from the narrowest sense to provide programming for the schools in the State as well as to meet the adult learning and the other educational needs of the people of the State of Georgia.

We are heavily dependent upon the funding for the CPB directly and indirectly, to do the job well. The indirect funding made possible through your committee, and by Congress, provides the major programming that we have all begun to expect from public broadcasting such as MacNeil-Lehrer, American Playhouse, Sesame Street, and other programs that are important to meeting the needs in Georgia, and these are the programs that the people look to, will cause them to make their own personal contributions to public television on a local level.

That way, the mix of the Federal and local dollars makes the impact much greater. We have a major responsibility in Georgia to provide educational programming to the schools. We broadcast five days a week, seven hours a day, instructional television schedule, and we know over 150,000 individual school children weekly use at least one program that we broadcast.

Cumulatively, it is over 2,000,000 users of our ITV service, and we have been able to deliver during off-hours times other kinds of programming that they can record off the air and have at their leisure in the library to further enhance the use of educational television in the schools.

In the summer, we provide some assistance by providing other kinds of pre-school education programs like Sesame Street, Reading Rainbow, 3-2-1 Contact, and I am delighted, Mr. Chairman, in large part, due to the Federal funding that will be available this next year, Georgia is able to expand its broadcasting schedule to a full 18 hours a day, seven days a week, each week of the year during this next year, to enable us at times when children are on vacation, Christmas, Easter, Thanksgiving, and summer months, to provide a full slate of programming of outstanding children's programming, in contrast to what is available on commercial television.

This we see as a great service, the best we can provide in Georgia, and it is made possible because of the funding that has been provided from the Congress to the CPB.

We know at least 180,000 pre-school children in Georgia watch Sesame Street each day, and other programming that is having a great impact with the State of Georgia, some types we are getting into now, outreach programs, and that is where the impact is much greater than a one or two-hour program seen at night.

The Chemical People was an example of this. We created in local communities over 450 local committees to deal with the problem of drug use and abuse locally. This program helped to convince these people that they could do something about it, and we are looking forward to the next Chemical People, which will feature Mrs. Nancy Reagan.

Project Literacy is coming up this year, and we are pleased with that in the South, joint project between PBS and the American Broadcasting Company, and it will feature the 43-lesson series, GED Series, which has been redone recently, and that is going to be made available to the States for us to use, to provide closed-circuit, all over the Nation for that matter, who do not have high school educations and that lack of the diploma keeps them from being employable or employed.

In Georgia, we are going to use this in a unique way, and we are working with the prison system and will be able to provide that series into the prisons, as a part of the inmates' rehabilitation there.

I can't say enough about what the impact is and the value of public broadcasting in Georgia in these ways. Another area, with the Federal dollars that are made available, great significance, local productions, we do six half-hour regular programs weekly in Georgia, about Georgia issues, everything from communicating our State Government to the people on a continuing basis to a program called Georgia Digest, items of key interest to the State, legal system, problems of the aged, or whatever might occur.

One of the areas we were fortunate enough to do a program that won a national award, the Dignity of the Mentally Retarded, which was selected as the best example of a media statement about the mentally retarded.

I could go on about the value of Federal dollars, and I would be delighted to answer any questions about the national system, or about Georgia. We depend on this money, the money made available from Federal funding, and we urge so much that by 1989 we do have that $238,000,000 secure and available, so we can plan now in order that by that time, outstanding programs that require the cooperation of funding of all the stations built on the Federal dollars, that these programs will be available in the program pipeline, and that the people of America will continue to have their lives enriched by public broadcasting.

Thank you again, Mr. Chairman, and I look forward to being able to assist this committee in your deliberations on this very important matter in the future.

Mr. NATCHER. Gentlemen, thank you very much.

[The statement of Messrs. Fannon and Ottinger follows:]

STATEMENT OF

PETER M. FANNON
PRESIDENT, NAPTS

RICHARD E. OTTINGER
CHAIRMAN, NAPTS
(Executive Director,
Georgia Public Telecommunications Commission)

NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

BEFORE THE

SUBCOMMITTEE ON

LABOR, HEALTH & HUMAN SERVICES, EDUCATION
AND RELATED AGENCIES

OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

ON

APPROPRIATIONS FOR THE

CORPORATION FOR PUBLIC BROADCASTING

FOR FY1989

MAY 6, 1986

Mr. Chairman and Members of the Subcommittee, it is a pleasure for us to appear before you once again to provide this testimony in support of funds for FY1989 for the Corporation for Public Broadcasting (CPB).

First and foremost, however, we would like to thank you on behalf of the nation's non-commercial public television stations for your outstanding support last year in maintaining CPB's crucial forward funding process by providing an appropriation of $214 million for FY1988. The entire public television community -- 317 non-commercial, not-for-profit stations licensed to 184 community organizations, schools, colleges, universities, and local and state governments -- is very grateful for your support. Our stations continue to need the underpinning of support that forward funding provides in order to commit to future program plans that fulfill their mission to educate, inform, and enrich all Americans. With reasonable assurance on the levels of federal support available in the near future, stations can seek the other, private funds necessary to embark on major new program series, better local programming, and new public service projects for our society.

Summary of recommendation

We thank you for denying the President's rescission request, issued with his February budget, of $44 million from the $214 million appropriated last year for FY1988. We urge this Subcommittee to continue its strong support for public broadcasting.

In order merely to maintain the level of service provided by public broadcasting in FY1982, CPB estimates the total need for federal support for FY1989 at $288.8 million. These figures represent the difference between the cost of maintaining the 1982 service level and the total amounts that are expected to be available from all other non-federal sources, including state and local governments, colleges and universities, businesses, foundations, individuals, and ancillary activities. Mindful of the severe budget constraints, therefore we ask that the Subcommittee recommend an appropriation of $238 million for FY1989, the full amount authorized.

For the last two years, on the recommendation of this Subcommittee in conference with the parallel Senate Subcommittee, the Congress has appropriated funds for CPB without a signed authorization even though the Congress had passed such legislation. Those sums were $200 million for FY1987 and $214 million for FY1988. This year, we are glad to report that Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1986, contains within its provisions reauthorizations for CPB through FY1990.

More than $238 million in FY1989, then, would be required in order to promote "real" growth in the coming years and in order to reach levels of excellence in programming and community service. But we want to tell you how public broadcasting is faring now with current programs and what plans we have for FY1989 funds.

Momentum builds as new challenges are faced

Public television is continuing to attract more viewers in homes, schools, and businesses. Financial support from individuals has grown to new, higher levels. These individual viewer contributions now constitute the second largest sector of public television's income after contributions from state governments. This progress has resulted from years of effort nationwide, based on reasonable, stable levels of federal support, to plan programs and activities to meet the needs and expectations our country has of public television.

Last year in our testimony, we reported to you that for the first time in many years public television's fall season would feature no new major American-produced series. This was the result of the severe reductions in public broadcasting made four years prior to the 1985 season.

As you are probably well aware, it takes years -- typically three to five -- to develop and bring to the air quality programs. And, in our non-profit business, it is extremely difficult to assume any financial risk for the commitments necessary to bring these programs about. That is why advance appropriations for CPB are so important. It is the means by which public broadcasting can ensure it has the childrens, educational, cultural, scientific, and information programs for the years ahead. For example, in January of this year the public television stations committed to finance 26 major or limited series in total, including four new ones. This represents an increase in hours of total programming and brand new programming for public television stations -- valued at over $100 million -- and the stations themselves have already contracted for some $40 million of that, with the rest to come from underwriters and co-producers. The addition of the four new series shows that public television is beginning to rebuild its programming momentum, and, with the stability and certainty of the programming funding available to stations and CPB through the appropriation to CPB, we can now commit to production, talent, and schedules for making important new programs.

While federal support is vital to the production and purchase of national programming for local public television stations, local program production is equally important and also benefits directly from federal funding. Local news, public affairs, candidate debates, state house coverage, and educational and outreach programs are the special activities public television stations schedules. Most of our stations are in the process of rebuilding their local services; much had to be sacrificed when the 1981 cuts became reality. If their funding were cut, their local productions would be the first casualties and the best of such efforts would never be available nationwide.

The lack of "blockbuster" series can affect public television's income. One need only look to public television's corporate income figures from last fall -- $29.1 million in October 1985 versus $55.2 million in October 1984. It is true that corporations will only finance certain programs for certain periods. It is also true that corporate underwriters want to be assured that the programs are part of a vital, broad service; they cannot and do not carry the whole burden.

Steady growth in federal support is vital to the program pipeline.

The program funding activities at CPB, as well as the Community Service Grants to individual public television stations distributed by CPB, will remain crucial to developing programs for public television well into the 1990's. Retaining CPB support for current series, as well as challenging new program ideas from stations and other producers, is vital to maintaining our support from our viewers and other funders.

Capitol Journal, public television's half-hour weekly series hosted by Hodding Carter on the nation's lawmaking process and its lawmakers, is in its second season and looking toward its third with the support of CPB and the public television stations.
In its most recent season, Capitol Journal, produced by WETA/Washington, has focused on issues ranging from children in poverty to unrest in the Phillipines to the shuttle tragedy, all from the vantage point of the nation's congressional leaders and policymakers.

Continuing in its second season as a one-hour daily news program, MacNeil-Lehrer Newshour from WNET/New York and WETA/Washington provides its viewers with an in-depth, balanced analysis of the news of the day. With its many awards and other recognition, it remains the standard by which the industry may measure its performance. Frontline, the weekly news documentary series produced by WGBH/Boston regularly attracts acclaim for its examination of controversial social and political issues which in recent months have included Central America, the Mideast, AIDS, and tax reform.

The trendsetting family drama series Wonderworks continues to draw critical and educational acclaim, presenting thought-provoking and exquisitely produced mini-series and individual programs to a rapidly growing audience. This season, the series presented "Maricela", the story of a teen-aged Salvadoran refugee and her American employer finding their way toward friendship and understanding, "The Lone Star Kid", the story of the 12-year-old mayor of Crabb, Texas, and "Anne of Green Gables", a four-part dramatization of L.M. Montgomery's childhood classic.

Continued support from CPB to two of public television's premiere performance series also remains crucial to fulfilling their mission of celebrating the very best of this nation's cultural achievement. Both American Playhouse and Great Performances continue to bring classics and brilliant new works in theater, music and dance to audiences who otherwise would never have the opportunity to experience them.

Public television's commitment to children continues.

Whether it involves providing programming for pre-schoolers at home, special reading programs for the summer, or instructional television in the classroom, public television is continuing and expanding its unique learning signal to our nation's children.

On the heels of the success of Sesame Street, The Electric Company, and 3-2-1 Contact, the Children's Television Workshop is readying its new mathematics series for 8-12 year olds to be aired in the next year. These programs will be seen by close to 20 million children at home and in school this year.

Reading Rainbow, the summertime weekly reading series for children hosted by LeVar Burton of Roots fame and produced by WNED/Buffalo and the Nebraska Educational Television Network, has prompted measurable interest in summer reading by children nationwide. According to the results of survey completed by RMC Research of children's librarians, 46% of those surveyed reported an increase in summer reading prompted by the series, 67% of the librarians attributed at least some degree of increase in book circulation to the series, and, most importantly, 75% believed the series also stimulated parents' interest in children's reading. The results of this national survey paint Reading Rainbow as an unqualified success from the perspective of children's librarians and energetic in the sense of overall activity in homes and libraries as children and parents made the connection between television viewing and the enjoyment of reading good books.

New, additional funding this year and next from the National Science Foundation will allow Reading Rainbow to produce four new science reading episodes in each of the next two years. It is hoped that the success the program has had will be augmented by this new attention to science education.

Public television stations continue to be valuable community resources.

Cooperative efforts between public television stations and their communities can be powerful vehicles for human resource and social services on both national and local levels. Organized national outreach programs revolving around television programming has proven to be successful in focusing attention on and helping to ease social problems, and local emergency, informational and educational public television services have had great impact on many communities.

Because of the national outreach success of The Chemical People, an innovative anti-drug program produced by WQED/Pittsburgh, communities around the country this year will participate in The Chemical People II hosted by First Lady Nancy Reagan. This program will focus on some of the secondary effects of drug abuse on our nation's teenagers, including teenage pregnancy, youth unemployment, and illiteracy.

An unprecedented national effort has been launched this year by PBS and ABC to help combat one of the nation's major social problems -- adult illiteracy. Project Literacy U.S. (PLUS) will consist of a wide range of national network broadcasts and community activities in an attempt to raise awareness nationally and generate ways of dealing with the problem on a local level. During the first phase of the project, the Public Television Outreach Alliance -- stations WQED/Pittsburgh, KCTS/Seattle, WETA/Washington, the Nebraska Educational Network, and the Kentucky Educational Television Network -- will conduct seminars and workshops around the country to mobilize and train community task forces on the issue. In the second phase, ABC News will present a documentary on the plight of the nation's 23 million illiterate adults, followed by a PBS documentary that will examine successful methods of dealing with the problem. Special public service announcements and news reports on ABC will supplement the programming, as will many ongoing projects from public television stations inlcuding a series called "The American Ticket" from KCET/Los Angeles, and the collaboration of Kentucky and Arkansas state networks to promote registration for Graduate Equivalency Diplomas (GED).

Individual stations have also had success in facing the pressing social problems of their viewing areas. On station that has had enormous success on a variety of issues is WTVS/Detroit. In response to startling increases in joblessness, WTVS initiated the Communication/Information System for the Unemployed (CISU) and the Working Channel not only to provide "job bank" information and job matching, but also to root out the problems of the long-term unemployed in the Detroit area. The station has also had great success in dealing with the problems of high school dropouts and adult illiteracy by working with state agencies, educational institutions, and their own resources.

Growing numbers of adult learners have taken advantage of the wide range of college courses for credit offered by public television stations and accredited by local universities and community colleges. The "non-traditional" learners -- older students, parents, or those with full-time jobs -- are particularly well-served by these courses which offer rigorous and challenging curricula that can be viewed at home. New national course offerings include "The Story of English", an historical look at the English Language, "The Business File", an introduction to business administration, and "The Mechanical Universe", an introduction to physics.

Conclusion

Federal funding remains the essential component of public television's income. Sufficient levels of federal support will guarantee that seed money remains available for the develpoment of new programs. With predictable federal funding, public television stations can continue to provide for community needs, as well as carry national programming.

Public television stations are hoping to continue building momentum that will see new series and programs in the coming seasons and not to relive last fall's disappointment of having no new major domestically-produced series in the season's lineup. This coming year will see the premieres of "American Masters" a 15-part series of profiles of great American artists, "Adventure", an eight-part production featuring true tales of estraordinary people facing great challenges, and "The Day the Universe Changed", a ten-part production on how new knowledge can transform man's understanding of the world.

In the coming years, we are looking forward to the completion of projects like "The Search for Mind" a nine-part sequel to "The Brain", "The Africans", an extraordinary series hosted by an African scholar that explores the history, future, and mysteries of Africa, "Who are the Russians?", a ten-part look at the Soviet Union, and "Heritage: Christianity", an examination of the history of Christianity. For the '86-'87 season, nearly $25 million still needs to be raised to bring the national program schedule productions currently in progress; for the '87-'88 season, unfunded needs for new programs total $78 million.

Any cutbacks in federal funds for public broadcasting will certainly affect public television stations' ability to produce, purchase, and broadcast these programs and to serve their communities. We thank this Subcommittee for its leadership in providing the full authorized level of support for FY1988, and ask that you consider supporting an appropriation of $238 million for FY1989.

TUESDAY, MAY 6, 1986.

EMPLOYMENT AND TRAINING ADMINISTRATION AND BILINGUAL EDUCATION

WITNESS

HON. MATTHEW G. MARTINEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. NATCHER. Our next witness is our friend and colleague from California, Mr. Matthew Martinez. We will be delighted to hear from you.

Mr. MARTINEZ. I am here today wearing two hats, on behalf of the Congressional Hispanic Caucus, and the other on behalf of myself as chairman of the Subcommittee on Employment Opportunities.

Let me start with my subcommittee's concerns first, and I want to thank you for giving me this opportunity to address the important issues of the fiscal year 1987 funding for employment and training programs under the jurisdiction of my subcommittee.

In this category is the Job Training Partnership Act, which contains the Job Corps, Summer Youth Employment Programs, Title III programs for dislocated workers, and Title II–A block grants to the States.

I would also like to speak about the work incentive program for AFDC recipients. These programs have been successful in providing an opportunity for people who have two strikes against them to hit a safe ground ball, if not a home run, and it is important that they continue to have that chance. Funding for these programs should not be reduced.

We hear a lot about how well the economy is doing, and we hear a lot about the great economic recovery. Unfortunately, not everyone in America is getting a piece of that pie.

In fact, in Ohio, Pennsylvania, parts of Illinois and other places I have visited with my subcommittee, the unemployment rate is double or nearly double the national rate, and unemployment among minorities and youth is sky high.

No one talks much about the massive layoffs that have created depression-like situations for these people. This waste of human capital creates crime, despair, disillusionment, and increases in welfare dependency.

It is a drag on the economy to the tune of $30,000,000,000 for every 1-percent increase in the unemployment rate. Still, it seems the Administration is more interested in buying missiles than in investing in job training for dislocated workers or "getting America back to work," as the President says in so many of his speeches.

For example, 11,500,000 workers were displaced from their jobs between 1979 and 1984. Even so, funding for programs that retain dislocated workers has been cut 55 percent since 1984.

Even though America's dropout rate continued to rise, the Job Corps, a 20-year success story in training and educating severely disadvantaged youth, is targeted for a 45-percent reduction, and programs from summer youth employment and training have been cut from $825,000,000 in fiscal year 1985 to a proposed $428,000,000 in fiscal year 1987.

Altogether, the Job Training Partnership Act stands to lose $639,000,000, and work incentive program, which provides job training and placement assistance for AFDC recipients, is targeted for total elimination.

Any way you look at it, these cuts don't make sense. It is economic folly to dismantle programs that are designed to enhance the employability of the dislocated and economically disadvantaged. Let's place them in jobs, and remove them from the welfare rolls.

Isn't this what the Administration says it wants? If so, why are we trying to chop the legs out from under the very programs that have been successful in reducing welfare dependency?

While it is true that these programs carry a price tag, the price is fair and it is small compared to the future cost of throwing away the talent and drive of a vast number of Americans through misdirected budget cuts.

Mr. Chairman, these cuts must be rejected, and funds removed from JTPA Title III dislocated workers program must be restored in the House, as they were in the Senate with the support of Senate Republicans.

[The information follows:]

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COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
518 HOUSE OFFICE BUILDING ANNEX #1
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SUBCOMMITTEE ON EMPLOYMENT OPPORTUNITIES

March 24, 1986

Congressman William Natcher, Chairman
Subcommittee on Labor, Health and Human
Services, and Education
2333 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Natcher:

I am writing to voice my strong opposition to the rescissions and FY 1987 budget cuts proposed by the Administration in job training and employment programs under the jurisdiction of my Subcommittee. I'm sure we both share the President's concern about the budget deficit, but the problem cannot be solved by cutting or eliminating useful, cost-effective programs. Rather, we must take positive steps to get people back to work and back on the tax rolls, and to make the most of those programs which give the government a healthy return on investment.

The Job Training Partnership Act (J.T.P.A.) accomplishes that goal through training programs which help the disadvantaged become useful, productive citizens. For example, throughout its 20-year history, the Job Corps (J.T.P.A. Title IV-B) has helped over 1.2 million severely disadvantaged youth through counseling, remedial education, and skills training. Also,studies have shown returns on investment of between 38% and 45% in this program. In spite of this, the Administration sought to eliminate this program in FY 1986 is now seeking a whopping $197 million rescission for FY 1986, and budget cuts of $265 million for FY 1987. Altogether, these rescissions and cuts would amount to a 45% reduction from FY 1986 to FY 1987 in a program that is making money for the government. Obviously, these cuts must be rejected.

Title III of the J.T.P.A. provides job search and relocation assistance, and job retraining to dislocated workers. A closely related program, trade adjustment assistance, establishes training program linkages and provides income maintanance to dislocated workers. Trade adjustment assistance (T.A.A.), which is currently funded at approximately $90 million, has been targeted for elimination by the Administration; they claim these workers would be better served under Title III of the J.T.P.A.

However, the Administration is requesting only current level funding of $100 million for Title III in FY 1987 plus a one-time supplemental appropriation for FY 1986 of $74 million, which would come from the elimination of T.A.A.. Unfortunately, this $100 million figure reflects a cut of 55% from FY 1985, and training programs will continue to reach only 5% of the eligible population despite increased demand. If these requests are approved, total funding for dislocated workers programs will have dropped from $313 million in FY 1985 to $100 million in FY 1987, a total of 68%. Without additional funding for Title III and continuation of trade adjustment assistance, too many Americans, unemployed as a result of free-market policies, will continue to fall through the cracks.

Also, the Administration wishes to eliminate funding for the Work Incentive Program (WIN), currently funded at $226 million. WIN provides child care, job training, and job placement for those receiving Aid to Families with Dependent Children. This program also has a track record of success: for example, the Commonwealth of Massachusetts' highly cost-effective WIN program, called Employment and Training Choices, has utilized Federal grants, state matching funds, and the involvement of 6,000 private-sector businesses to help 23,000 participants find jobs and leave the welfare rolls. Previously, in FY 1984, the WIN program helped 350,000 people move from the welfare rolls into unsubsidized employment. Nonetheless, WIN lost $47 million in appropriations from FY 1985 to FY 1986. The Administration has requested a $46 million rescission for FY 1986 and total elimination of this program by October 1, 1986, even though every state has expressed an interest in implementing programs similar to the one in Massachusetts.

If the Administration is allowed to gut the Job Training Partnership Act and eliminate the WIN and trade adjustment assistance programs, there will be a resultant loss in human potential which America can ill-afford. Therefore, I believe it would be very helpful and informative if you, Chairman Hawkins of the full Education and Labor Committee, and I could jointly discuss these issues. Please contact me at your earliest convenience so that I can arrange a mutually convenient time.

Sincerely,

Matthew G. Martinez, Chairman
Subcommittee on Employment Opportunities

Mr. **Martinez**. Let me go to my concerns as expressed by the members of the Congressional Hispanic Caucus.

I appreciate the opportunity to provide my views on the proposed bilingual education fiscal year 1987 budget, and I am here on behalf of the Congressional Hispanic Caucus, 14 members, are all strong supporters of the bilingual education program. I would like to voice some of our concerns over the fiscal year 1987 budget request and its implications.

Of great concern to me and the Members of the Caucus is the continued lack of services and/or the inadequacy of services provided to limited English-proficient children. We believe that this grave problem is being exacerbated by the statistics the Department of Education is currently using to determine the size and need of the limited English-proficient student population.

The Department of Education estimates in its 1986 report on bilingual education that there are 1,200,000 to 1,700,000 limited English-proficient children in the United States. However, Dr. Dorothy Waggoner, a specialist in language minority statistics, notes that if one applies the Department's standards of English proficiency to the numbers of language-minority children counted in the 1980 Census, the number would be closer to 3,500,000 to 5,300,000 limited English-proficient children in the U.S.

And this population is growing rapidly. In just a six-year period, 1976 to 1982, the limited English-proficient student population increased 27 percent while the general student population declined by 13 percent.

It is estimated that by 1990, one-fourth of all school-age children will be limited English-proficient children. Furthermore, the limited English-proficient population is concentrated in some of America's largest States.

California alone has 500,000 limited English-proficient students, half of whom reside in Los Angeles County. Other States with growing limited English-proficient student populations are Florida, Illinois, New York, Texas, Arizona and New Mexico. Half of these students are Spanish-speaking and the other half is comprised of students who speak Vietnamese, Cantonese and Tagalog as well as over 80 other languages.

Nonetheless, this fast-growing group continues to be underserved by our educational system despite being among the largest and most educationally needy student populations.

In 1982, then Secretary of Education Terrell Bell estimated that only a third of limited English-proficient students receive bilingual education or English as a second language instruction.

Only 10 percent of limited English-proficient students are served by Title VII funded programs. The Department's Office of Bilingual Education and Minority Language Affairs testified that preliminary description from the national longitudinal evaluation found that 94 percent of students were being served in 1983.

But if one looks at New York City alone, this cannot be the case. Although there are over 100,000 limited English-proficient children in New York, only 30 percent of these children are receiving full bilingual education. Nearly 40 percent receive no special language assistance at all.

The educational price we pay for the neglect of these children is too high. Hispanic studies are dropping out of school in record numbers, from 40 percent in Miami to 50 percent in Los Angeles to as high as 80 percent in New York.

Given the previous statistics, it is reasonable to assume that it is not because of bilingual education that these students drop out; rather, it is the lack of any sort of special language services, which aid in the acquisition of basic skills to meet promotion requirements, for many of our Nation's limited English-proficient children.

Moreover, the Caucus is concerned about the continued underfunding of programs authorized by the 1984 Bilingual Education Reauthorization Act.

For example, the Family English Literacy Program, designed to help parents of limited English-proficient children learn English, is severely underfunded.

A recent New York Times article noted that 48 percent of adults in the U.S. whose native language is one other than English are illiterate in English. Yet of 37 applications for Family English literacy funding in fiscal year 1985, only four were funded.

In fiscal year 1986, the Department only re-funded the original programs; no new programs were funded.

I believe that parental involvement in a child's education is of paramount importance. So, too, does Secretary Bennett and the Department of Education. According to the publication, "What Works," "parental involvement helps children learn more effectively."

It goes on to recommend that parents drill children in subjects such as spelling, read to children aloud and help children with their homework. The question is, then, how can a parent help a limited English-proficient child if he or she is limited English-proficient? The Family English Literacy Program needed to be expanded, not curtailed.

I would like to ask the subcommittee to review the funding process for the National Clearinghouse on Bilingual Education. It is my understanding that there has been undue upheaval in the process which the Department is utilizing to fund the Clearinghouse.

I would ask the subcommittee to investigate in order to ensure the Clearinghouse's survival and that there be no interruption or diminution of the vital services it provides.

I would also like to voice the concern of the Caucus over the continued funding of the National Advisory and Coordinating Council on Bilingual Education.

This Council has overstepped its bounds as an advisory body to become a forum for anti-bilingual education rhetoric. Several members of the Caucus have been outraged by disparaging remarks made by several members of the Council about the Hispanic community and its leadership, including characterizing bilingual education as the "new Latin hustle."

We urge the subcommittee to zero-fund the Council for fiscal year 1987 as the Council has ceased to be a body for responsible and useful discussion.

Finally, I urge the subcommittee to adopt report language to ensure that the Department of Education regulations for the implementation of the 1984 Act, due out shortly, fully reflect legislative intent.

The Caucus wants to ensure that the Secretary's recent "Bilingual Education Initiative," not subvert, through the appropriations process or through legislation, the legislative intent of the bipartisan Bilingual Education Reauthorization Act of 1984 or diminish the long-standing Federal commitment to educating our language-minority children.

Mr. Chairman, if you have any questions, I would be glad to answer them.

Mr. NATCHER. Thank you very much, Mr. Martinez.

TUESDAY, MAY 6, 1986.

GENERAL ASSISTANCE TO THE VIRGIN ISLANDS AND TERRITORIAL TEACHER TRAINING

WITNESS

HON. RON DE LUGO, A DELEGATE TO CONGRESS FROM THE TERRITORY OF THE VIRGIN ISLANDS

Mr. NATCHER. Our next witness is our friend and colleague from the Virgin Islands, Mr. Ron de Lugo. Come around, Mr. de Lugo, we will be pleased to hear from you.

Mr. DE LUGO. Thank you, Mr. Chairman.

I am glad to be here to say a word about my two programs of concern to my particular constituency.

For the past six years, Congress has appropriated funding for these programs and each year the President's budget requests a recision of the appropriations made.

I just want to thank the Chairman and other members of this subcommittee for the bipartisan support given to these programs which are so essential to the functioning of the Virgin Islands school system.

Congress reauthorized the programs in 1984, as part of Public Law 98-511. The appropriations I seek are for the full amounts authorized: $5,000,000 in general assistance and $2,000,000 for all of the territories in teacher training assistance. This is the same amount appropreated last year for each program.

Your support for these programs over the years suggests the subcommittee's familiarity with their success and importance.

General assistance funds would supplement local education expenditures. Education is the biggest single budget allocation in the Territory, accounting for a quarter of the budget. As recognized by the authorizing legislation, the education demands made by the resident community are considerable, and leave little flexibility to respond to the laudable but costly Federal requirement that non-citizens be educated.

Federal immigration policy required the Virgin Islands to accommodate far more non-citizens than is reasonable, given the Territory's size and economy. Because we are part of the United States, the Virgin Islands is a magnet for those in the eastern Caribbean chain of islands who come in search of opportunity, which is even more elusive in their native islands.

While I was successful in passing legislation that eliminates the poorly-run temporary worker program in the Virgin Islands, the schools are still struggling to accommodate children of immigrants, illegals and beneficiaries of the terminated H-2 program. These children compose over 10 percent of the local student body: of the 25,450 students in local public schools, 3,500 are non-citizens..

The teacher training assistance is a means of addressing another facet of the education problem facing the Virgin Islands, and the other U.S. Territories. The program is designed to build the pool of local teachers with a view towards reducing the hazardous reliance on teachers from the mainland. Severe problems have resulted from such reliance.

Mainland teachers are often not prepared to cope with the cultural differences both in the island communities and in their students. The result is a problem both in qualification and continuity.

Through grants which go to territorial colleges, the teacher training program helps insular areas to train local people who understand the cultural setting, and who are committed to the community and its schools. While the majority of the teachers in the Virgin Islands are still from the mainland, the program has significantly increased the local pool of teachers, and I understand it has worked equally well.

I have tried today to refresh your memories on the importance of the general assistance and teacher training programs to the Virgin Islands. I firmly believe that dollars allocated to the programs yield sufficient returns to warrant the funding requested, and I say with full appreciation for the budgetary constraints this committee is bound to address.

I ask that my full statement be included in the record and will be happy to answer any questions the members of this subcommittee may have regarding these two programs. Thank you for your consideration.

Mr. NATCHER. Mr. de Lugo, thank you very much. You have given us an excellent statement.

[The statement of Mr. de Lugo follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR-HEALTH AND
HUMAN SERVICES-EDUCATION

HEARING ON THE FISCAL YEAR 1987 APPROPRIATIONS

STATEMENT SUBMITTED BY
RON DE LUGO, M.C.

MAY 6, 1986

MR. CHAIRMAN,

I COME BEFORE THIS SUBCOMMITTEE TO REQUEST FUNDING FOR TWO PROGRAMS, GENERAL ASSISTANCE TO THE VIRGIN ISLANDS AND TEACHER TRAINING FOR EACH OF THE U.S. INSULAR AREAS. EACH YEAR, CONGRESS HAS APPROPRIATED FUNDING FOR THESE PROGRAMS AND MAINTAINED THAT FUNDING, DESPITE NO ALLOWANCE FOR THE PROGRAMS IN THE PRESIDENT'S BUDGET REQUESTS AND RESCISSIONS PROPOSED FOR APPROPRIATIONS MADE BY THE CONGRESS. I WANT TO THANK YOU IN PARTICULAR, MR. CHAIRMAN, FOR YOUR CONTINUED SUPPORT FOR THESE PROGRAMS. I ALSO WANT TO THANK MEMBERS OF THIS SUBCOMMITTEE FOR THEIR BIPARTISAN SUPPORT.

CONGRESS REAUTHORIZED THE GENERAL ASSISTANCE AND TEACHER TRAINING PROGRAMS IN 1984, AS PART OF PUBLIC LAW 98-511. THE APPROPRIATIONS I SEEK ARE FOR THE FULL AMOUNTS AUTHORIZED: FIVE MILLION DOLLARS IN GENERAL ASSISTANCE TO THE VIRGIN ISLANDS AND TWO MILLION DOLLARS FOR ALL OF THE TERRITORIES IN TEACHER TRAINING ASSISTANCE.

APPROPRIATIONS MADE OVER THE YEARS SUGGESTS THE SUBCOMMITTEE'S FAMILIARITY WITH THE SUCCESS AND IMPORTANCE OF THESE PROGRAMS. GENERAL ASSISTANCE FUNDS WOULD SUPPLEMENT LOCAL EDUCATION EXPENDITURES. EDUCATION IS THE LARGEST SINGLE BUDGET ALLOCATION IN THE TERRITORY, ACCOUNTING FOR A QUARTER OF THE BUDGET. AS RECOGNIZED IN THE AUTHORIZING LEGISLATION, THE EDUCATION DEMANDS MADE BY THE RESIDENT COMMUNITY ARE CONSIDERABLE, AND LEAVE LITTLE FLEXIBILITY TO RESPOND TO THE LAUDIBLE, BUT COSTLY FEDERAL REQUIREMENT THAT NON-CITIZENS BE EDUCATED.

FEDERAL IMMIGRATION POLICY REQUIRED THE VIRGIN ISLANDS TO ACCOMMODATE FAR MORE NON-CITIZENS THAN IS REASONABLE GIVEN THE TERRITORY'S SIZE AND ECONOMY. BECAUSE WE ARE PART OF THE UNITED STATES, THE VIRGIN ISLANDS IS A MAGNET FOR THOSE IN THE EASTERN CARIBBEAN CHAIN OF ISLANDS WHO COME IN SEARCH OF OPPORTUNITY WHICH IS EVEN MORE ELUSIVE IN THEIR NATIVE ISLANDS. WHILE I WAS SUCCESSFUL IN PASSING LEGISLATION THAT ELIMINATES THE POORLY RUN TEMPORARY WORKER PROGRAM IN THE VIRGIN ISLANDS, THE SCHOOLS ARE STILL STRUGGLING TO ACCOMMODATE CHILDREN OF IMMIGRANTS, ILLEGALS AND BENEFICIARIES OF THE TERMINATED H-2 PROGRAM. OVER THE YEARS, THE VIRGIN ISLANDS HAS EDUCATED 30,000 OF THESE STUDENTS IN ITS

ELEMENTARY AND SECONDARY SCHOOLS. OF THE 25,450 STUDENTS IN LOCAL PUBLIC SCHOOLS, 3,500 ARE NONCITIZENS. IF SECOND GENERATION CHILDREN ARE INCLUDED, FOR EXAMPLE THOSE BORN IN THE VIRGIN ISLANDS WHOSE PARENTS WERE TEMPORARY WORKERS, THE NUMBER WOULD INCREASE TO OVER FIFTY PERCENT OF THE STUDENT POPULATION.

THE ADMINISTRATION HAS SUGGESTED THAT THE VIRGIN ISLANDS MAY REPROGRAM FUNDING RECEIVED UNDER CHAPTER TWO TO HANDLE SOME OF THE CONSTRUCTION PROJECTS THAT THE VIRGIN ISLANDS MUST PROVIDE IN ORDER TO ACCOMODATE ITS STUDENT BODY. WHILE THE VIRGIN ISLANDS MAY CONSOLIDATE ITS FEDERAL PROGRAMS TO CONCENTRATE FUNDS ACCORDING TO WHERE THE MOST PRESSING NEED LIES, THERE IS NO AUTHORITY TO SPEND THIS MONEY FOR PROJECTS WHICH ARE OUTSIDE OF EXISTING AUTHORIZATIONS. EVEN IF THERE WERE, THE VIRGIN ISLANDS IS STRUGGLING TO PROVIDE A DECENT EDUCATION TO ITS STUDENTS AS IT IS. TO SPEAK OF REPROGRAMMING FUNDS IGNORES THE FACT THAT THE FUNDS REPROGRAMMED,FOR CONSTRUCTION WOULD LEAVE OTHER IMPORTANT EDUCATIONAL OBJECTIVES WANTING.

THE TEACHER TRAINING ASSISTANCE IS A MEANS OF ADDRESSING ANOTHER FACET OF THE EDUCATION PROBLEM FACING THE VIRGIN ISLANDS, AND THE OTHER U.S. TERRITORIES. THE PROGRAM IS DESIGNED TO BUILD THE POOL OF LOCAL TEACHERS WITH A VIEW TOWARDS REDUCING THE HAZARDOUS RELIANCE ON TEACHERS FROM THE MAINLAND. SEVERE PROBLEMS HAVE RESULTED FROM SUCH RELIANCE. MAINLAND TEACHERS ARE OFTEN NOT PREPARED TO COPE WITH THE CULTURAL DIFFERENCES BOTH IN THE ISLAND COMMUNITIES AND IN THEIR STUDENTS. THE RESULT IS A PROBLEM BOTH IN QUALIFICATION AND CONTINUITY.

THROUGH GRANTS WHICH GO TO TERRITORIAL COLLEGES, THE TEACHER TRAINING PROGRAM HELPS INSULAR AREAS TO TRAIN LOCAL PEOPLE WHO UNDERSTAND THE CULTURAL SETTING, AND WHO ARE COMMITTED TO THE COMMUNITY AND ITS SCHOOLS. THERE ARE 174 STUDENTS CURRENTLY IN THE VIRGIN ISLANDS TEACHER TRAINING PROGRAM. FIFTY-SIX TEACHERS HAVE GRADUATED, AND ALL ARE TEACHING IN LOCAL SCHOOLS. WHILE THE MAJORITY OF THE TEACHERS IN THE VIRGIN ISLANDS ARE STILL FROM THE MAINLAND, THE PROGRAM HAS SIGNIFICANTLY INCREASED THE LOCAL POOL OF TEACHERS.

THE ADMINISTRATION HAS SUGGESTED THAT THE OBJECTIVES OF THIS PROGRAM MAY BE ACHIEVED UNDER ITS PROPOSED STATE GRANT TEACHER TRAINING PROGRAM. THE PROPOSAL WOULD ROLL A NUMBER OF TRAINING PROGRAMS INTO ONE, AND WOULD HAVE A 75 MILLION DOLLAR BUDGET. THE THRUST OF THAT PROGRAM, HOWEVER, WOULD BE DIFFERENT THAN THE TEACHER TRAINING PROGRAM SPECIFICALLY FOR THE TERRITORIES. WHILE THE THRUST OF THE PROPOSED STATE GRANT PROGRAM, AS I UNDERSTAND IT, IS TEACHER EXCELLENCE, THE TEACHER TRAINING PROGRAM PROVIDES AN AVENUE FOR THE TERRITORIES TO CATCH-UP WITH THE MAINLAND. THE TERRITORIES ARE CURRENTLY INTERESTED IN PROVIDING A LOCAL STOCK OF TEACHERS WHO HAVE DEGREES AND TEACHING CERTIFICATION. WHILE WE ARE ALL INTERESTED IN EXCELLENCE, THE TERRITORIES NEED THE

TARGETED FUNDING PROVIDED UNDER THE TEACHER TRAINING PROGRAM. I WILL GIVE YOU AN EXAMPLE. MORE THAN 250 SENIOR STUDENTS AT THE PUBLIC HIGH SCHOOL ON ST. CROIX DON NOT HAVE MATH AND ENGLISH TEACHERS. THESE STUDENTS HAVE BEEN DOING "INDEPENDENT STUDY" UNDER THE SUPERVISION OF VOLUNTEERS.

I HAVE TRIED TODAY TO REFRESH YOUR MEMORIES ON THE IMPORTANCE OF THE GENERAL ASSISTANCE AND TEACHER TRAINING PROGRAMS. I FIRMLY BELIEVE THAT DOLLARS ALLOCATED TO THE PROGRAMS YIELD SUFFICIENT RETURNS TO WARRANT THE FUNDING REQUESTED, AND I SAY THIS WITH FULL APPRECIATION FOR THE BUDGETARY CONSTRAINTS THIS COMMITTEE IS BOUND TO ADDRESS.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS THE MEMBERS OF THIS SUBCOMMITTEE MAY HAVE REGARDING THESE TWO PROGRAMS, AND THANK YOU FOR YOUR CONSIDERATION.

TUESDAY, MAY 6, 1986.

CORPORATION FOR PUBLIC BROADCASTING

WITNESS

DAVID BRITT, EXECUTIVE VICE PRESIDENT, CHILDREN'S TELEVISION WORKSHOP

Mr. NATCHER. Our next witness is Mr. Britt, and we will be pleased to hear from you at this time.

Mr. BRITT. Thank you, Mr. Chairman. I have a longer statement which I will submit for the record.

I am Executive Vice President of Children's Television Workshop. I am here to urge you and the subcommittee to support appropriation of at least the authorized level of funds for the Corporation for Public Broadcasting for fiscal year 1989; and to direct the Department of Education to commit more funds for fiscal year 1987 for educational television, particularly in the areas of science and math.

Funds from CPB will be used in part by public television stations to help support Sesame Street. Funding has been provided by both CPB and the Secretary's discretionary funds of the Department of Education for 3-2-1 Contact, our educational television series that makes science more appealing and understandable to millions of 8 to 12-year-olds, as well as our new mathematics series, also for 8 to 12-year-olds.

The new mathematics series will help address the national crisis in math education by using the power of television to motivate children to learn and use mathematics and to acquire problem-solving skills.

CPB and DOE have each committed $3,000,000 to the first season of the math series. Additional funds are being provided by the National Science Foundation, two private foundations and the IBM Corporation.

Federal funds are essential to leverage private monies into a project of this type. Other funders have already expressed interest in Season Two, but it appears that DOE will not, thus threatening to break down the funding consortium essential to continue.

NSF made a five-year commitment to provide $1,500,000-plus each year for 3-2-1 Contact. The planned funding effort included matching money from DOE.

However, DOE has provided only $1,000,000 per year for the first three years, and plans to provide no funds at all in the future.

CPB has been providing $1,000,000 each fiscal year toward 3-2-1 Contact, and plans to continue to do so for at least two more seasons.

Just as we can put together for the first time a daily hour of educational programming for 8 to 12-year-olds in math and science, DOE is ending its support, leaving a gap of at least $3,000,000 per year for minimal continuation of this national attack on a major educational crisis.

Experts agree that the United States will lose its edge in economic and technological competition with other countries without a very rapid improvement in science, engineering and mathematics education.

That problem begins in the elementary grades when most children lost interest in these subjects.

We can help by giving sustained attention to children's educational television, a mechanism that is already in place, is highly cost-effective—for example, 3-2-1 Contact costs only one penny per person per viewing—and is available and appearing to rich and poor, girls and boys alike.

Math and science illiteracy is a national fact of life, but there are no television illiterates; children watch on average 27 hours per week, as much or more time as most spend in school.

Your support has shown that children's television can be constructively educational. Our own programs, such as Sesame Street and 3-2-1 Contact have proved that children will watch, pay attention to and learn from educational programming carefully designed and effectively produced for them.

The backbone of public television is its children's educational television service, the children's block. Therefore, we urge you to support full funding for the Corporation for Public Broadcasting.

Similarly, direct Federal funding is necessary for continuation of programs such as 3-2-1 Contact and our math series. We urge that the Department of Education be directed to provide more funding for educational television for our children, particularly in the crucially important areas of science and math.

Thank you.

Mr. NATCHER. Thank you very much, Mr. Britt. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Mr. Britt follows:]

Testimony by David V.B. Britt

Executive Vice President

Children's Television Workshop

Before the House Appropriations Subcommittee

Labor-HHS-Educationon

Tuesday, May 6, 1986

11:40 a.m.

Subject: Corporation for Public Broadcasting

Department of Education/Educational Television

Mr. Chairman and members of the Subcommittee:

Thank you for the opportunity to appear before you today. I want to urge the Subcommittee to maintain an adequate level of quality educational television programming for this nation's children. Specifically, I am here to ask you and your Subcommittee to:

-- support the full authorized level of funds for the Corporation for Public Broadcasting for FY 1989;

-- encourage the Department of Education to commit more funds for educational television, particularly in the areas of science and math.

Children's Television Workshop has a direct interest in these appropriations. Community Service Grants from CPB will be used in part by public television stations to help support SESAME STREET; funding has been provided by both CPB and the Department of Education for 3-2-1 CONTACT (our educational television series that makes science more appealing and understandable to millions of 8-to-12 year-olds); and our major new mathematics series SQUARE ONE TV, also for 8-to-12 year-olds.

This new mathematics series will help address the national crisis in math education by using the power and impact of television:

-- to promote enthusiasm for and interest in mathematics;

-- to encourage the use and application of problem-solving strategies in mathematics;

-- and to present sound mathematical content in an interesting and meaningful way.

The 75 half-hour programs wil be suitable for viewing both at home and in the classroom, and teacher guides will be available. The anticipated airdate is January 1987. As with 3-2-1 CONTACT, we anticipate that the series will be broadcast by most of the public television stations around the country both during the day for in-school use and in the late afternoon for home viewing.

CPB and DOE have each committed $3.0 million to the math series. The National Science Foundation is providing $5.0 million and additional funds are being provided by Carnegie Corporation of New York, the Andrew W. Mellon Foundation and the IBM Corporation. Federal funds are essential in leveraging private monies into a project of this type. With federal support in place, our discussions with IBM resulted in a major production grant from them, and IBM is the first corporation in a long time to make a large committment to children's programming.

Other funders have already expressed interest in Season Two of the math series, but it appears that DOE will not continue its participation, thus threatening to break down the funding consortium essential for continuation.

Regarding our children's science series, 3-2-1 CONTACT, the National Science Foundation made a 5 year commitment to provide $1.5 million plus each year. The planned funding effort had included matching money from DOE. However DOE has provided only $1.0 million in each of 3 years and plans to provide no funds for the future. This lack of continuation funding from DOE seriously threatens our ability to continue production of the minimal 20 shows per year. This is particularly bad news when, for the first time, we are in a position to be able to begin to put together a daily hour of educational programming for 8-to-12 year-olds (a half-hour of math and a half-hour of science, 3-2-1 CONTACT).

CPB has been providing $1.0 million each fiscal year toward 3-2-1 CONTACT and plans to continue to do so for at least two additional seasons.

Season one of the new math series is the first significant addition of new programming to the PBS children's block since 3-2-1 CONTACT started in 1980. This children's block is the only sustained educational programming available for children. Since children are going to watch television anyway, it is crucial to provide and sustain entertaining and informative age-appropriate programming for them. Continuation of these programs of science and math education at minimal levels faces a gap of at least $3 million per year in DOE funds.

A report issued in March by the prestigious National Science Foundation Board states "The deterioration of collegiate science, mathematics and engineering education is a grave long-term threat to the nation's scientific and technical capacity, its industrial and economic competitiveness, and the strength of its national defense." The report says that fewer students are choosing careers in science and engineering, that certain specialties are not attracting the entrants they need and that enrollment in teacher education in mathematics and the sciences is "critically low."

Mr. Chandler, President of the Association of American Colleges said "The United States cannot keep its technological edge and its edge in economic competition unless there is very rapid improvement in education in science, engineering and mathematics."

The above mentioned report focuses on the college level. However, the national problem with scientific and math literacy starts at the elementary grades, where teachers are least prepared to teach science or math. The fact is that children in this country -- most especially girls and minorities -- are uninterested and turned-off by math and science by the time they begin high school. Positive motivation, interest and a sense that they can master these subjects needs to occur in the elementary years.

These, of course, are precisely the goals of 3-2-1 CONTACT and our math series. Television can supplement work in the schools, and do things visually in these subjects which most schools simply cannot.

Each week on average 4 million viewers watch 3-2-1 CONTACT at home. With the combination of some new programs each year and repeat airings of earlier seasons, 3-2-1 CONTACT costs only one penny per-person per-viewing.

Children's Television Workshop works hard to ensure that our programs have an impact beyond the screen. 3-2-1 CONTACT teacher's guides are provided and teacher training workshops conducted around the country. Over 750,000 copies of the teacher's guide have been distributed so far. Strong participatory activities are taking place with a variety of organizations such as science museums and the Girl Scouts of America. Science clubs for children based on the series are also gaining momentum, with club packages and activity guides being provided. Similar activities will take place around the math series.

Children are a very under-served portion of our population. Senator Moynihan's book "Family And Nation" points out the declining condition of this nation's children, which is largely a result of the changing family structure, specifically the increase in the number of single-parent families. They are the "new" poor of our country.

We can help them by giving sustained attention to children's television -- a mechanism that is already in place to provide additional programming. It is a highly cost effective means of supplemental education -- available and appealing to rich and poor -- girls and boys alike.

It is vital to increase the momentum of constructive programming at a critical time in our children's lives.

Math and science illiteracy is a national fact of life, but there are no television illiterates -- children watch it every day. From six to eleven years-old, on average they watch 27 hours per week -- as much, or more, time as most spend in school.

Our choices are not limited to trying to mitigate the widely perceived bad effects of television for children. With your support childrens television can be constructively educational and cost effective. Our own programs -- SESAME STREET, THE ELECTRIC COMPANY, 3-2-1 CONTACT, as well as other educational programs, have proved that children will watch, pay attention to and learn from educational programming carefully designed and effectively produced for them.

In many respects the backbone of public television is its educational services, and it is these services that are the most dependent on Federal funding. The Corporation for Public Broadcasting needs and merits your full support.

Federal funding is essential to ensure the production of programs such as 3-2-1 CONTACT and our math series, and the Department of Education is an essential funding source for these educational television efforts.

We urge that the Department of Education be directed to provide more funding for educational television, as a cost-effective investment in the education of our children, and particularly in the crucially important areas of science and math.

Thank you.

TUESDAY, MAY 6, 1986.

CLOSED-CAPTIONING PROGRAM

WITNESS

JOEL D. ZIEV, EXECUTIVE DIRECTOR, NEW YORK SOCIETY FOR THE DEAF, NATIONAL CAPTIONING INSTITUTE

Mr. NATCHER. Our last witness is Mr. Joel Ziev, and we will be pleased to hear from you at this time.

Mr. ZIEV. I am going to be signing, one of our staff members is deaf and they have asked me to sign.

We do have a written statement from Mr. John Ball of the National Captioning Institute, but I would like to present, or I would like to comment on my own, speaking on behalf of the National Captioning Institute.

I am the father of a deaf son, who is 21, a little bit younger than David, and also the Executive Director for the Deaf. Through those experiences, I really believe I know and understand the critical need for continued government support for closed-captioning.

The support for the closed-captioning program, subsidies for the Telecaption-II decoder, and the need for financial support to assist in the development of a third generation decoder as described in an NCI report.

I share NCI's belief that the future of service for deaf persons is dependent on the fact it must be available to the widest possible deaf audience at a price they can afford.

Thanks to the generosity of this committee, I am happy to report that a new decoder can now be purchased for only 60 percent of the cost of the original decoder.

NCI should be commended for its leadership role in bringing to the deaf community a more modern, less expensive machine. I am happy to tell you that I have been advised by NCI that more than 40,000 of these new decoders have been sold in the past four months.

That is tremendous. That is more than five times the sales level of the preceding years. It is important to note that a deaf person in America only earns about 73 percent of the annual income of other hearing people.

The New York Society for the Deaf is now celebrating its 75th anniversary of services to deaf persons. We ourselves have a membership of more than 800 adult deaf persons, and we served last year more than 2,200 deaf people.

That is a large group. Most of our people that we serve are from the minority communities of New York City. Unfortunately, most of the people we serve are not even able to afford the new unit.

Therefore, the need for additional support for the decoder is critical. It is very, very important, but I can also testify that we must provide some funds, the financial support necessary, to bring the price of the decoder down even further, and that needs to be done before the end of this decade, to make it available to a larger group of people.

I have also learned through my son and from my position with this Society and through our members, of the importance and the tremendous benefits that closed-captioning has brought to the deaf community.

My son and others like him now have an opportunity to learn language through this more natural way and be aware of what is going on in the world through reading.

The television is giving him access to this wonderful field of information for better or worse. Sometimes it is good. Sometimes it is bad, but he still has the equal opportunity to get access and to make individual judgments that were not available to him before.

I am only sorry that the service was not available when he was younger. He is of the closed-captioning generation. We started having a decoder when he was 16 in 1980, and he has had an opportunity through these years to watch television.

He can discuss programs with his father now. He knows what is happening in the news. He reads the newspaper more because he sees the visual pictures on the television screen. We argue about watching some of the programs on HBO, and some of the other programs and who is going to watch, but that is not really an argument, that is wonderful, normal.

An argument of a father with a normal 21-year-old, not a father who before had to interpret programs for his son, and because he was interpreting, his choices of programs were usually different than mine.

We always got into arguments. You are laughing, Dave, it is the same in your home, also. I know of the tremendous educational benefits that all deaf children can receive by being able to access television.

The New York Society for the Deaf was honored to present an award to Sesame Street last week, part of our 75th Anniversary celebration for their work in closed-captioning and in using sign language as part of their television program.

They have increased tremendously the awareness of the world to deaf people, and I commend them also.

I really must ask the committee support in acting on NCI's request for additional funds for programs, especially in the area of children's programming. The need of the children younger than my son would can start with the decoder, and closed-captioning is wonderful and the world is now open to them as never before.

This reading experience that is necessary by watching and reading and knowing what is going on more than only the action and the violence.

Most deaf people before the decoder enjoyed the action and the violence of a program not really ever knowing what was happening. Deaf people do not have access to the radio, ways of getting information that is timely. Television gives them that access, and the news programs that are available each night in real time captioning are phenomenal.

If something happens in Russia that is terrible, if something happens in New York or anywhere in the United States, deaf people can now know that it is happening, the same as others, and not wait for something to happen the next day or the next week or see which is worse.

Other people frantic. What is happening? Is the hurricane going to hit us? NCI closed-captioning service has reduced the isolation that has been met by deaf persons when they are away from other deaf people.

It has provided opportunities for my son and other deaf persons to gain equal access to this important medium of television. This access permits television to be used as a learning tool for the improvement of reading skill, as a source of vital and timely information, and as an appropriate leisure activity, the same as others.

The service provided by NCI is an important annual one. It is one that has broadened communication and life experience for hearing-impaired Americans.

Some of the ways that we as the New York Society for the Deaf are planning to make available other decoders to some of our clients as people buy the new decoder, we are recommending that they donate their old decoder to the Society, and we will reassign them to people who cannot afford them now, so they might not get the fancy decoder with all the good things on it, but they will still have equal access the same as other people to the decoder and to closed captions.

Through the continued support by this committee, this special group of constituents, those who are deaf, those who cannot use the television, the radio, or gain access to television or a meeting like this without special accommodation, really will benefit significantly from this very, very important and vital service.

I would be pleased to answer any questions you might have. I am sorry for the awkwardness of my sign language, I am a little bit nervous. Thank you very much.

Mr. NATCHER. Mr. Ziev, thank you for your statement. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Mr. Bail follows:]

STATEMENT OF THE
NATIONAL CAPTIONING INSTITUTE ON
FY 1987 APPROPRIATION FOR CLOSED-CAPTIONED TELEVISION

BEFORE THE

LABOR, HEALTH, & HUMAN SERVICES AND RELATED AGENCIES SUBCOMMITTEE

OF THE

HOUSE ON APPROPRIATIONS

JOHN E.D. BALL

PRESIDENT, NATIONAL CAPTIONING INSTITUTE

May 6, 1986

Testimony of John E. D. Ball, President
National Captioning Institute, Falls Chuch, Va. before
Subcommittee on Labor, Health, & Human Services and Related Agencies
on Appropriations
U.S. House of Representatives
May 6, 1986

The National Captioning Institute (NCI) appeciates this opportunity to submit testimony in support of the FY 1987 budget needs of the Media Services and Captioned Films Branch of the U.S. Department of Education. NCI is now in its seventh year of service to the nation's hearing-impaired population, providing each year increasing access to television through its unique Line 21 closed captioned television technology. The Line 21 technology has become a defacto technical standard in North America and is fully compatible with the television standards common to the broadcasters, cablecasters and home video industry. The service requires the hearing-impaired viewer to purchase a "decoder" and attach it to his TV set in order to see the captions.

Since NCI submitted testimony last year, many encouraging developments have taken place and significant strides have been made towards extending the service to all hearing-impaired citizens. This progress stems in large measure from the strong support NCI continues to receive from Congress. Earmarking funds specifically to foster the growth of the service has played a major role in the progress to date. While it can be reported that the TV industry now fully endorses the service, and that its financial support is growing, it is still not at a level that would sustain the service. Federal support of the service still remains vital.

Back in 1980, NCI was established with federal funds, as a non-profit corporation to furnish captioning services to the TV industry and thereby open up the airwaves to hearing-impaired people for the first time. At that time a total of 15 hours of pre-recorded programs were captioned each week and broadcast on ABC, NBC and PBS. Today, almost 100 hours of programming are available every week, including live newscasts. All of the networks now cooperate in the provision of the service. Indeed last fall ABC became the first network to offer its full prime time schedule of programs with captions. More recently CBS announced it was increasing its volume of captioned programs. Also the Corporation for Public Broadcasting increased its financial support to ensure that hearing-impaired people could watch more public TV programs. The cable TV industry is showing commitment too and was recently commended by the President for its efforts (see Attachment 1). Showtime and Home Box Office now provide many of their programs with captions every week. The fast growing home video industry has also become a major supporter with CBS/Fox and RCA/Columbia among the leaders. Many television program producers, syndicators, advertisers and philanthrophic institutions are among the growing list of private sector supporters of the service. An interesting cooperative endeavor is the Pew Memorial Trust and ABC joint funding of "This Week with David Brinkley," captioned every Sunday morning; the first Sunday morning public affairs show to be captioned. NCI has also been successful during the past year in attracting to its Board of Directors, prominent figures in the television industry and the field of education (see Attachment 2). The NCI Corporate Advisory Council (CAC) has experienced a significant growth in membership during the past year under the chairmanship of Mr. Gerald Robinson, President and chief operating officer of The Kellog Company and with the strong support of Mr. Stuart D. Watson, Chairman, Heublein Inc., retired (see Attachment 3). The two major activities of the CAC are:

1) To advise and assist NCI in extending the captioning service to the largest possible segment of the hearing-impaired community by the end of this decade. (The CAC has set as the goal, at least 500,000 households. As part of that activity the CAC adopted a major national project through which low income deaf families and deaf school children will be able to buy decoders for much less than the recommended retail price of $199.99. NCI has instituted two such pilot programs; one in Detroit and one in Chicago in which deaf school children can obtain a decoder for as little as $35.00).

and 2) To assist NCI to obtain greater financial support from the TV industry with the ultimate goal of having all TV programs captioned and paid for with non-federal funds.

NCI's Consumer Advisory Board (CAB), a group of prominent deaf leaders and professionals who work in the field of deafness, continues to be NCI's prime communication channel with the deaf community (see Attachment 4). The CAB oversees the disposition of the funds NCI receives through its Caption Club. Last year over 3,000 individuals and organizations contributed more than $100,000 to the club. NCI uses these funds as matching or challenge monies to persuade TV producers and others to share the cost of captioning their programs. The CAB also performs important information dissemination functions for NCI and has contributed much towards increasing the awareness of the closed captioning service within the deaf community.

The major event during the past twelve months clearly was the introduction of the new decoder, TeleCaption II. NCI spent close to two years and over $300,000 to develop this second generation device that incorporates the latest TV technology (see Figure 1). Its predecessor had been developed with federal monies back in 1979 and 100,000 were sold to the hearing-impaired community for approximately $280.00 each. Thanks to action taken by Congress, the Department of Education awarded NCI $1,500,000 to subsidize the manufacture of 50,000 Telecaption II units. As a result the unit became available in January of this year at a recommended retail price of $199.99, a 40% reduction in price over the previous unit. In actual fact the unit has been offered by some of NCI's dealers for as little as $160.00! The demand for the unit has exceeded all expectations. In little over three months 36,000 units have been ordered. Revised sales projections suggest that close to 100,000 units could be sold this year. This is surely compelling evidence that lowering the price of the unit and increasing the amount of captioned programming are essential for the healthy growth of this vital service. The appreciation of hearing-impaired people extends clear across the nation:

> "Recently I received a closed caption decoder as gift. No one knows how grateful I am. My heart is full! I am so grateful to you who spend so much time, cost and thoughtfulness in getting the captioned programs. Thanks is not enough!"
>
> Paia, Maui,
> Hawaii.

As has been said, "No one buys a hammer just to own it!" This is also the case, of course, with the decoder. Hearing-impaired people will only buy the unit if it provides them with access to a reasonable and growing volume of programs. The current fare of captioned programs seems a lot until it is compared to the programs that hearing people not only have available but actually watch today. Excluding cable TV programs and home video, the average home in many cities and towns today can select from over 1000 hours of broadcast programs each week. That's ten times the total amount of captioned programs. Also, the average home watches 50 hours of television every week. Until very recently there were no captioned programs broadcast for close to a ten hour period during the daytime. Now thanks to Procter & Gamble, the NBC midday program "Search for Tomorrow" is captioned. Hopefully, this is only the first of many daytime programs that will be captioned in the not too distant future.

> "I am a senior citizen of over 80 and
> I missed so much enjoyment because of
> my hearing loss. But with your machine
> I can enjoy my programs again."
>
> Howard Beach, New York

Many in the hearing-impaired community lose their hearing as a result of growing older. Accordingly, as the population ages, the number of hearing-impaired people will increase and closed captioning will assume an even greater social importance. However, for the old and infirm, captioned programs must be available during the daytime and early evening hours, if this large segment of the hearing-impaired community is to be adequately served by the service. Much remains to be done before captioned programs become a regular feature of daytime programs. NCI is committed to opening up that portion of the television schedule. Many in the private sector can be persuaded to follow Procter & Gamble's example. However, federal government support of captioned programs must be maintained if these efforts are not to be cancelled out by a reduction in federal monies. The service is still at a stage of evolution where the involvement of the private sector is conditional and dependent on the continuing involvement of the federal government.

> "I am 87 years and don't get out much especially evenings and it means so much to me that there is always a good program that is captioned. I listen to the 6:30 a.m. news in the morning and also Peter Jennings at 6:30 p.m. Lately there is a closed captioned news program at 6 p.m. on Saturday and Sunday."
>
> Fort Myers, Florida

Hearing-impaired people very much appreciate the closed captioned TV service and constantly write to NCI to express their thanks that more and more programs are being captioned for them. NCI can continue to make steady progress in this regard only if it retains the undiminished support of the federal government.

Children who are deaf form a special audience group that have all too few captioned programs. NCI's research shows that captions help them learn to read. There are thousands of deaf children that do not have decoders in their homes. As previously mentioned, NCI is attempting to solve the decoder shortage problem in cooperation with its CAC. However, more captioned children's programming must also be made available. Federal monies specifically earmarked for this purpose need to be allocated.

A sizable number of captioned children's programs every week could attract a second group i.e., learning disabled children. A recent study that NCI conducted, under a grant from the Department of Education, showed that captioned TV can be a useful educational tool for these special kids (see Attachment 5). It is understood that at least 1,500,000 learning disabled children are currently enrolled in the public school system. Parents of learning disabled need to become informed about the potential benefits of closed captioned TV for their children. Attracting that audience could transform the whole economic balance of the service and sharply reduce its dependence on federal support. NCI will be exploring this new service potential in the near future.

While this testimony hopefully indicates that the non-federal support of the closed captioning service is growing at an encouraging pace, it should also be making it clear that federal funds continue to play a critical role at this time.

In FY 1986 Congress appropriated $17,500,000 for Media Services and Caption Films and specified that $5,700,000 be used for closed captioned TV as follows:

Captioned programs:	$4,000,000
Decoder subsidies:	$1,000,000
Decoder development:	$ 500,000
Public awareness & consumer aid:	$ 200,000
	$5,700,000

Expenditures are not as yet complete for FY 1986.

In FY 1987 NCI recommends that Congress appropriate for Media Services and Captioned Films, with earmarking as indicated below, a total of $7,500,000 for closed captioned TV:

Captioned programs:	$5,000,000*
Decoder subsidies:	$1,500,000**
Decoder development:	$ 500,000***
Public awareness & consumer aid:	$ 500,000****
	$7,500,000

* This would reflect an increase of $1,000,000 over FY 1986, but we recommend that these additional funds be restricted to the captioning of children's programming.

** This would permit additional decoders to be manufactured to meet the high demand. This amount would subsidize a minimum of 50,000 units at $30 each.

*** Decoder development remains to be a most important activity so as to reduce the manufactured cost and hence the consumer price of a third generation unit to be available in the 1988-89 timeframe.

****All too little has been done to alert the public and particularly the hard-of-hearing population about the service.

NCI believes the above are critical funding areas that fit the leadership role that Congress has played in the development and growth of the closed captioned TV service. If the goals NCI has adopted in concert with its CAC are reached by the end of this decade, the service will have reached maturity and be accepted as any every day facet of our nation's television service with little or no need for further federal support.

NCI wishes to express its sincere appreciation for the confidence Congress and the Department of Education has shown in giving NCI such a crucial role to play in the development of this so vital a service for so many previously ignored hearing-impaired people. The National Association of the Deaf recently expressed its appreciation to NCI also (see Attachment 6). We believe we have been true to our mission and we intend to continue to earn such confidence through our future endeavors. Thank you for this opportunity to submit this testimony.

Attachment 1

THE WHITE HOUSE
WASHINGTON

I want to commend the National Captioning Institute for enabling hearing-impaired people to enjoy television more fully through closed captioning.

Your work is an outstanding example of how personal compassion can lead to constructive action, and make itself felt across the nation. It represents the cooperation I have long encouraged between the public and private sectors.

I especially want to commend Showtime/The Movie Channel, Viacom, the Miller Brewing Company, Maljack Productions, NCI's Caption Club, and 19 additional cable companies. With their generous help, "The Honeymooners" will be closed captioned for hearing-impaired viewers throughout the country.

Nancy is as enthusiastic about this work as I am, and joins me in wishing success and happiness to everyone involved.

Ronald Reagan

Attachment 2

NATIONAL
CAPTIONING
INSTITUTE,
INC.

NCI BOARD OF DIRECTORS

The National Captioning Institute is governed by a Board of Directors representing varied fields of expertise who individually have a demonstrated interest in the public good, particularly as it relates to television and hearing-handicapped citizens.

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*Executive Committee

2/26/86

Attachment 3

nci
NATIONAL
CAPTIONING
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INC.

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OF THE
NATIONAL CAPTIONING INSTITUTE

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Walt Disney Home Video
Warner-Lambert Company
Xerox Corporation

Volunteer Consultant

Mr. Stuart D. Watson, Chairman, Heublein Inc., retired

(46 members)

4/4/86

Attachment 4

NATIONAL
CAPTIONING
INSTITUTE,
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Elizabeth Spellman Cranston, Rhode Island	Director Adult Services & Sign Language Program Rhode Island School for the Deaf
Charles Williams Cleveland, Ohio	Yard Superintendent Cuyahoga County Engineer's Department

5/14/85

Attachment 5

Research Report 86-1
February 1986

CLOSED-CAPTIONED TELEVISION: A NEW TECHNOLOGY FOR ENHANCING READING SKILLS OF LEARNING DISABLED STUDENTS

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Research Report 86-1
February 1986

CLOSED-CAPTIONED TELEVISION: A NEW TECHNOLOGY FOR ENHANCING READING SKILLS OF LEARNING DISABLED STUDENTS

ABSTRACT

In the past five years a new dimension called closed-captioning has been added to television viewing. Closed captions are subtitles which enable viewers to read the dialogue of a program. A growing number of educators beleive that these captions provide a new source of reading material which can aid in the enhancement of reading ability. The present study was designed to investigate the effects of closed-captioned television upon the reading performance of learning disabled students. Specifically, it investigated four treatment conditions: 1) viewing TV with captions and sound, 2) viewing TV with captions and no sound, 3) viewing conventional TV with sound but no captions, and 4) reading the printed text of captions, with respect to student's sight vocabulary, comprehension and oral reading.

Seventy-seven learning disabled students, reading on the 1st through 3rd grade levels, were randomly assigned to one of the four treatment conditions. They viewed or read (according to condition) four different segments from the TV science series 3-2-1 Contact over a three week period. The results of this study suggest that both captioned-TV-with-sound and conventional TV are well worth exploring as media for enhancing reading skills. The results of this study suggest that the addition of captions to conventional TV may be an effective means of enhancing word recognition skills and enabling students to utilize the larger idea bearing units in text and focus on meaning.

CLOSED-CAPTIONED TELEVISION: A NEW TECHNOLOGY FOR ENHANCING READING SKILLS OF LEARNING DISABLED STUDENTS

In the past five years a new dimension has been added to television viewing. Each week more than 90 hours of television shows have closed captions which enable viewers to read the dialogue of a program. These captions, similar to subtitles on foreign language films, can only be seen on television sets equipped with a special electronic decoder. While captions were originally developed to help hearing-impaired people enjoy the benefits of television, they have the potential of enriching the lives of many other individuals. Captions provide a new source of reading material. They present the viewer with printed words in a motivating environment where the audio and video context can help readers understand words they might not know.

While television viewing often has been described in negative terms as a passive activity, some educators are now suggesting that television viewing is an active cognitive process. Anderson and Lorch (1983) claim that children will attend to television only as long as they have questions that need answering. This makes television a communication medium similar to other mediums, but one that promotes attention because of the high interest factors involved (Huston & Wright, 1983). Daniel Boorstin (1983), the Librarian of Congress, contends that reading books and watching television should be viewed as coexisting media for spontaneous education.

A growing number of educators, especially those who work with students with learning problems, believe captioning holds promise in serving as an aid to enhancing reading ability. While there is evidence in the literature that reading achievement has been improved when instruction has been based on popular TV programs (Ashley, 1982; Szabo & Lamiell-Landy, 1981) there is little information on the use of captioned TV with hearing populations. Initial reports on the use of this medium during teacher-directed reading instruction to enhance vocabulary, comprehension and oral fluency, however, suggest that captioned TV holds promise as an instructional tool (Koskinen, Wilson, & Jensema, 1985). There is also evidence which suggests that viewing captioned TV without teacher assistance improves student sight vocabulary (Adler, 1985).

Because of the very limited research in this area, there is a need to further explore the potential of captioned television. Questions of particular interest are whether captions add a meaningful dimension to the already motivating medium of television, and how captioned television compares with the more traditional experience of reading written text on a printed page. To explore these issues, the present study was designed to investigate the effects of captioned television upon the reading performance of learning disabled students. An attempt was made to take a systematic look at the effects of video, audio, and captions on certain aspects of reading achievement. Specifically, this study investigated whether there were differences among four treatment conditions: 1) viewing TV with captions and sound, 2) viewing TV with captions and no sound, 3) viewing regular TV with sound but no captions, and 4) reading the printed text of captions, with respect to students' sight vocabulary, comprehension, and oral reading.

METHOD

Subjects

Seventy-seven learning disabled students from four Maryland public schools participated in this study. The students were reading on the 1st through 3rd grade levels as determined by individualized reading tests, and at the 4th grade level or below on the Botel Word Opposite Test. They ranged in age from 9 to 13, were reading at least 2 years below their grade level, and were receiving State of Maryland Level 2 or 3 special education services which entitled them to 1 to 3 hours a day of special assistance.

Materials

The video/text materials for this project consisted of four excerpts from the children's science TV program 3-2-1 Contact. Since some students in this study were going to see TV programs and others were just going to read the program's text of captions, these materials had to be comprehensible to a reader who did not see the video action or hear the audio input. Because of this restriction, only a limited range of programming could be selected. Two experienced teachers viewed video tapes of children's programs to identify meaningful vignettes that had captions which could be understood without the accompanying audio or video. Forty-five vignettes were identified. These vignettes were then rated on a 1 to 5 scale in the categories of interest, educational value, and match between the content of captions and video action portrayed on the screen. Captions which were highly rated in all categories were then rated for comprehensibility and interest by a reading specialist who had not seen the videos.

The four video/text segments selected for use in this study had captions which were comprehensible when read without accompanying video or audio. They were also similar in content (science), interest level, word count (approximately 200 words), reading level (3rd-7th), length of the video segment (1.5-3 minutes), and caption speed (107-122 wpm). In addition, two five-minute captioned video segments were selected from 3-2-1-Contact programs and four two to three minute segments were selected from cartoon programming, such as Fat Albert and The Littles, to be viewed by all subjects involved in the study.

Parallel scripts were developed to assure consistency across the four treatment conditions. They included introductory material for each vignette, procedures for viewing or reading, and guidelines for administration of the assessment tasks.

Assessment materials developed for this study included word recognition, comprehension, and oral reading measures. A word recognition test, consisting of 20 content vocabulary words selected from the text of captions, was created for each of the four segments. Another 20-item word recognition test to measure delayed recall was also developed from words randomly selected from each of the four word recognition tests (five words per test). Two different types of comprehension tasks were developed for the four sessions. One of these was a 5-item cued recall test which included both textually explicit and textually implicit questions. Another comprehension measure involved the cloze procedure. Three cloze tasks were developed, two as practice activities and one as an assessment instrument. The cloze tasks consisted of deletions of selected content words from the text of captions. In addition, a 100 word passage for oral reading was selected from the captions of the video segment used in the final session.

Procedures

Students in each school were randomly assigned by Botel reading levels to one of the following four treatment conditions: 1) captioned-TV-with-sound, 2) captioned-TV-without-sound, 3) conventional TV, and 4) text-of-captions. Four researchers who were experienced reading teachers each worked with the four different treatment conditions in their assigned school. Students in each of the conditions met with the researcher four times over a three week period for the treatment sessions. Researchers worked with groups of seven or fewer students and each treatment session was approximately 1/2 hour in length.

During each of the four treatment sessions, students in Condition 1 viewed a video segment with audio and captions; students in Condition 2 viewed a video segment with captions, but without audio; students in Condition 3 viewed a video segment with sound but no captions; and students in Condition 4 read a printed copy of the video segment's captions. To help orient students to captioned television and the paper script of captions, students in each condition viewed a segment of captioned TV at the beginning of Sessions 1 and 2, and in Session 1 read a portion of the video's printed text of captions.

Students in each treatment session were given a brief one sentence introduction to the topic that was to be viewed or read and were also directed to read or watch carefully so they could remember the important ideas. After either viewing or reading a segment (according to condition), students participated in assessment activities. As a final activity for all sessions, students watched a short cartoon segment. These high interest vignettes were shown at the end of each session in an attempt to control for the motivating effects of television.

Assessment activities for the study involved the administration of word recognition, comprehension and oral reading measures. At each treatment session students were given a word recognition test and, six to eight days after the fourth treatment session, the subjects also completed a 20-item delayed word recognition test. In all sessions, sight word knowledge was assessed individually while the other members of the group worked on a maze or drawing activity. Cloze practice activities were given during the first and second sessions and a cloze test was administered during the fourth session. These cloze tasks required students to read a text with deletions and write in the missing words. In addition to these activities, students read the comprehension questions and wrote responses during the third session and their oral reading of the text of captions was tape recorded for subsequent analysis in the fourth session

The assessment instruments for this study were scored according to the following procedures. On the 20-item word recognition tests, subjects received 5 points for each correct response out of a possible 100 points. The 10-item cloze test was scored both for exact replacements and for semantically appropriate replacements. Subjects received 10 points for each acceptable response resulting in a possible score of 100 points for each analysis. On the 5-item question test, subjects received 2 points for each correct response resulting in a possible score of 10 points. For the oral reading miscue analyses, which involved scoring for both exact matches to text and semantically appropriate replacements, subjects received 1 point for each acceptable response resulting in a possible score of 100 for each analysis.

RESULTS

To verify the equivalence of treatment groups, a one-way analysis of variance was conducted on the Botel Word Opposites Test scores. No significant differences were found [$F\ (3,73) = .5642$, $p > .05$].

Multivariate repeated measures were used to analyze the word recognition scores for the four sessions. No significant differences were found among the four treatment conditions [$F(3,70) = 2.18$, $p > .05$]. A subsequent chi-square analysis using students scores which reached the criterion of 90% on the word recognition test was then conducted. The results revealed statistically significant differences in favor of the captioned-TV-with-sound group when compared to the text-of-captions group [X (1, N=35) = 7.20, $p < .01$], and in favor of the captioned-TV-with-sound group when compared to the captioned-TV-without-sound group [X (1, N=35) = 5.76, $p < .05$].

The cloze test was scored in two ways: 1) number of words which were an exact match with the text, and 2) number of words which were semantically appropriate. Analysis of variance procedures revealed no significant differences among treatment conditions for the number of words which exactly matched the text. However, statistically significant differences were found among the four treatment conditions for words which were semantically appropriate ($F(3,72) = 4.74$, $p < .05$). Post-hoc pair-wise comparisons using the Student-Newman-Keuls procedure revealed statistically significant differences in favor of the captioned-TV-with-sound group ($M = 46.00$) and the TV group ($M = 45.79$) when compared to the text-of-captions group ($M = 26.84$) and the captioned-TV-without-sound group ($M = 25.00$).

An analysis of variance of the scores on the cued recall test revealed significant differences among the treatment conditions ($F (3,73) = 5.72$, $p < .0014$). The significant differences were in favor of the captioned-TV-with-sound group when compared to the text-of-captions group and in favor of conventional TV when compared to the text-of-captions and the captioned-TV-without-sound groups.

Two scores derived from the oral reading miscue analysis were used in this study: 1) words accurately pronounced, and 2) words that were semantically appropriate. While analysis of variance results only approached significance for the words accurately pronounced [$F(3,71) = 2.63$, $p = .0568$)], statistically significant differences were found among the four treatment conditions for number of words which were semantically appropriate [$F(3,71) = 2.83$, $p < .05$]. Post-hoc pair-wise comparisons using the Student-Newman-Keuls procedure revealed statistically significant differences in favor of the captioned-TV-with-sound group ($M = 92.68$) and the captioned-TV-without-sound group ($M = 91.50$) when compared to the text-of-captions group ($M = 87.11$).

DISCUSSION

This study investigated the effects of four treatment conditions: 1) captioned-TV-with-sound, 2) captioned-TV-without-sound, 3) conventional TV, and 4) text of captions, upon the sight vocabulary, comprehension, and oral reading of learning disabled students. The results of this study strongly suggest that both captioned-TV-with-sound and conventional TV are well worth exploring as media for enhancing the reading skills of learning disabled students.

It is especially noteworthy that in this study captioned TV had a positive effect on the sight vocabulary of learning disabled students. A most promising finding was the significant performance on the word recognition tasks of the captioned-TV-with-sound group. While there were no significant differences on the repeated measures analyses, the chi-square analysis revealed significantly more instances of students scoring at or above 90% in the captioned-TV-with-sound group when compared to the text-of-captions and the captioned-TV-without-sound groups. This finding suggests that the addition of captions to conventional TV may be a significant factor in developing the word recognition skills of young children.

One of the most important dimensions of captioned television also presents a formidable research dilemma. The television video provides much of the information necessary for comprehension. Isolating and assessing the contribution of the captions to reading comprehension, therefore, is problematic, since such a strong framework for comprehension is provided by the video. Given this limitation, however, reading comprehension was assessed in the present study using a variety of measures. Comprehension was assessed using a cloze task, questions, and miscue analysis procedures.

On the cloze task, the captioned-TV-with-sound group and the conventional TV group did significantly better than the captioned-TV-without-sound and text-of-captions groups. On the questioning task, the captioned-TV-with-sound group did significantly better than the text-of-captions reading group. The conventional TV group was superior to both the text-of-captions group and the captioned-TV-without-sound group. These findings support the hypothesis that conventional TV, as well as captioned-TV-with-sound, enhance comprehension for disabled learners. The audio does not appear to interfere with young childrens' processing of the captions and, in fact, the findings of this study support the theoretical notion that simultaneous processing enhances learning.

With respect to the performance of subjects on the oral reading task, miscue analysis results for words accurately pronounced only approached significance. There were, however, statistically significant differences for words which were semantically appropriate. When compared with the text-of-captions group, both captioned TV groups (with and without sound) made significantly fewer semantically inappropriate miscues when reading words in context. This finding, while tentative in nature, can be interpreted as an indication that the addition of captions enabled the subjects to utilize larger language or idea-bearing units in the text and to focus on meaning.

It is important to note, that in this study the time subjects were engaged in each treatment condition was relatively brief. The actual viewing or reading was based upon approximatley 8-10 minutes of programming across the four sessions. In light of the very limited time of subject exposure and the positive findings in favor of captioned television, it is clear that this medium deserves further attention from reading researchers.

It appears that the dual coding of information through print and sound, combined with the powerful popular medium of television, holds promise as an educational tool. In this study subjects received no direct instruction and viewed each program only once. In this respect, the subjects viewing was similar to the typical home television viewing experience. Given the significant amount of time that young children view television (Huston & Wright, 1983) future research should explore the potential of captioned TV for developing and enhancing reading skills in the home environment.

Further research also needs to systematically investigate the use of captioned TV over extended periods of time, with materials of varying lengths, and when used as part of directed reading/language instruction. The benefits of using a variety of high interest programming, such as cartoons with young children and serial dramas with adolescents and adults, should be included in future research efforts. In addition, there is a need to explore the use of captioned TV with other types of learners, including pre-school children, adult beginning readers, and individuals who speak English as a second language. Television, which is sometimes said to contribute to reading problems, may now, with the addition of captions, be used as one of the solutions to these problems.

ACKNOWLEDGMENTS

This research was supported by a U.S. Department of Education grant. We would like to thank Douglas Coulson, Suella Klevenow, Roberta Atkinson, Florence Smith, and Elaine McLaughlin from the University of Maryland and the NCI support staff for their invaluable assistance on this project.

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NATIONAL CAPTIONING INSTITUTE, INC.

DEPARTMENT OF RESEARCH -- Jensema and Fitzgerald, authors

REPORT LISTING 1981

81-1	Audience Reaction to Football Scoreboard Captioning
81-2	1980 Closed Caption TV Audience
81-3	Audience Reaction to Inauguration Captioning
81-4	Unavailable
81-5	C-C Decoder Sales and the "Core" of the Hearing Impaired Community
81-6	A Survey of the Opinions of Closed Caption Decoder Owners
81-7	A Comparison of Three Groups Interested in Closed Captioning
81-8	A Report on the Mature American's EXPO in Tampa
81-9	A Survey of Captioned TV News Program Preference
81-10	Captioned Films and C-C TV Viewing by Clubs for the Deaf
81-11	Closed Captioned TV in Schools for the Hearing Impaired
81-12	A Demographic Profile of Households with Closed Captioned TV
81-13	The Closed Caption Television Viewing Preferences of Hearing-Impaired Children
81-14	Daytime Closed Caption Television Preferences
81-15	The Attitudes of Hearing-Impaired Viewers Toward Closed Caption TV Commercials
81-16	Closed Caption Decoder Ownership and Program Preferences Among Two Groups of Hearing-Impaired People

NATIONAL CAPTIONING INSTITUTE, INC.

DEPARTMENT OF RESEARCH -- Jensema and Fitzgerald, authors

REPORT LISTING: 1982

82-1	A Home Video Survey of a Sample of Households Having a High Percentage of Hearing-Impaired Residents
82-2	Public Awareness of Closed Caption Television in the Dallas/Fort Worth Metropolitan Area
82-3	Characteristics of the Closed Caption Television Audience on January 1, 1982
82-4	Audience Reactions to the Closed Captioned ABC World News Tonight
82-5	The Reaction of the Closed Caption Television Audience to Text Services
82-6	Public Awareness of Closed Caption Television in the Pittsburgh Metropolitan Area
82-7	Awareness of Closed Captioned Television Among Parents of Hearing Impaired Children
82-8	The Market for Closed-Captioned Cable Television in New York City

1983

83-1	The Propensity of Hearing Impaired Television Viewers in Two Cities to Subscribe to Cable to Obtain Closed Captioned Programming
83-2	Reactions to Captioned News Services
83-3	Characteristics of the Audience for Closed Caption Television on December 31, 1982
83-4	The Hard of Hearing Market for Closed Caption Television
83-5	Hearing Impaired Children's Comprehension of Closed Captioned Television Programs
83-6	Two Pilot Projects Which Used Captioned Television in Classrooms to Teach Reading to Hearing Children

NATIONAL CAPTIONING INSTITUTE, INC.

DEPARTMENT OF RESEARCH -- Jensema, Carl J.

REPORT LISTING: 1984

84-1	Characteristics of the Audience for Closed-Caption Television on December 31, 1983
84-2	School Use of Closed Captioned Television

1985

85-1	Characteristics of the Audience for Closed-Captioned Television on December 31, 1984
85-2	Using Closed Captioned Television in the Teaching of Reading to Deaf Students

1986

86-1	Closed-Captioned Television: A New Technology for Enhancing Reading Skills of Learning Disabled Students

Attachment 6

NAD
NATIONAL ASSOCIATION OF THE DEAF
301-587-1788
814 THAYER AVENUE
SILVER SPRING, MARYLAND 20910

WHEREAS, the National Captioning Institute, Inc., a non-profit organization which exists solely for the purpose of making television more accessible to hearing impaired citizens, has demonstrated that it really cares for the desires and needs of children, adults, infirm and underprivileged citizens whose hearing is impaired by promoting increasing access to all types of television programming through the use of closed captioning, and

WHEREAS, in addition to many popular network and cable television programs, NCI has arranged for hearing impaired viewers - either at its own expense or through the contributions of corporations/ foundations - access to the benefits of unique program services such as Program Listing Update Service (PLUS), Hearing Impaired News Text Service (HINTS), real time captioning for all presidential television addresses and press conferences, special news events such as the hostages crises, sports events such as the Super Bowl and World Series, and

WHEREAS, NCI has established and maintains excellent working relationships with all four major networks and all major cable television systems and has been the exclusive force behind the proliferation of closed captions on movies in videocassettes, and

WHEREAS, through extensive research and development NCI has been responsible for the production of a second generation decoding adapter which incorporates state of the art technologies while reducing the retail cost to a level which will make it affordable to thousands of hearing impaired persons who otherwise would be deprived of the educational, social, cultural and entertainment benefits of closed captioning, and

WHEREAS, accomplishment of all of the foregoing has evolved from the skills of NCI's outstanding staff personnel in securing contracts, corporate and foundation gifts, and contributions from enthusiastic and grateful consumers from all over the nation, many of whom also are members of the National Association of the Deaf, therefore

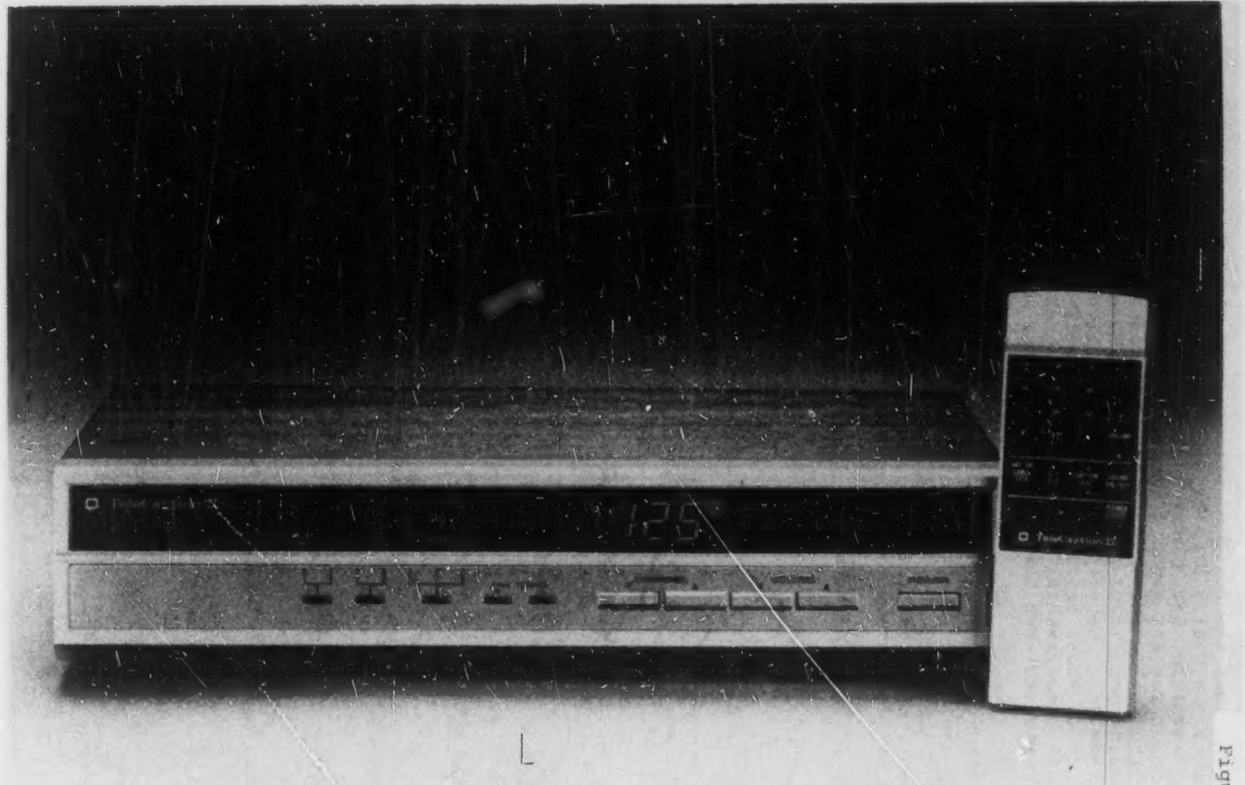
BE IT RESOLVED that the Board of Directors of the National Association of the Deaf expresses gratitude to the National Captioning Institute, Inc. for its varied contributions to life enrichment for all hearing impaired persons, and extends support to the continuing efforts of this agency to provide ever-increasing amounts of access to all forms of electronic media programs which benefit and enrich the lives of viewers of such programs whose hearing is significantly impaired by bringing full understanding and enjoyment, which in turn brings these otherwise isolated persons closer to the mainstream of society.

BE IT FURTHER RESOLVED that a copy of this resolution be included in the minutes of the meeting of the NAD Board of Directors, November 15-17, 1985, a copy be forwarded to the National Captioning Institute, Inc., and to the United States Department of Education.

Signed this 17th day of November, 1985.

Larry Forestal, President
HARVEY Jay Corson, Vice-President
John F Levesque, Sec'y-Treasurer
T. Alan Hurwitz, Past President
Lawrence Newman, Pres.-Elect
G Leon Curtis, Board Member IIII
Roslyn Rosen, Board Member I
Nancy B Rarus, Board Member IV
Jan Ann Stelter, Board Member III
[illegible] Walker Board Member III
Philip Bravin, Board Member I
Board Member II
Alan [illegible], Board Member II

Figure 1



WASHINGTON, D.C. - The National Captioning Institute (NCI) introduces TeleCaption II-the Second Generation Adapter.
The TeleCaption II Adapter (left) is state-of-the-art, sports a sleek new look, comes with 181 channel capacity (UHF, VHF and Cable), has a digital readout panel and carries a suggested retail price of $199.90.
The remote control pad (right) comes with TeleCaption II and allows the consumer to change channels from the comfort of an easy chair.

(NCI photo) (10-85)

-30-

CONTACT: Lottie W. Gatewood
Public Affairs Specialist
(703) 998-2462 (voice &TDD)

Mr. NATCHER. We will now recess until 2:00 p.m.

AFTERNOON SESSION

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESSES

HON. HAL DAUB, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

ROY BENNETT, ASSISTANT SUPERINTENDENT, BELLEVUE PUBLIC SCHOOL SYSTEMS, NEBRASKA

JOHN DEEGAN, BELLEVUE PUBLIC SCHOOL SYSTEMS

Mr. NATCHER. Mr. Daub, come around. Our first witness this afternoon is our friend and colleague in the House, Mr. Hal Daub. We will be pleased to hear from you.

Mr. DAUB. Thank you very much. It is always a pleasure for me to address you and your distingished colleagues. This program has been one of the bangboards of administration after administration in terms of the issue of whether or not this program we call impact aid ought to continue. With me are folks you have met before, Mr. Roy Bennett, Assistant Superintendent of the Bellevue Public School Systems, the home of Offutt Air Base, SAC Command, and his colleauge with the Bellevue School Systems, Dr. John Deegan.

I will present the formal testimony but in case there are questions, I brought the real experts with me who understand the program, have dealt with it, managed it and could be helpful to the committee.

Mr. Chairman, distinguished Members of the subcommittee, thank you for this opportunity to testify today on behalf of the school districts that receive impact aid funding in Nebraska's Second Congressional District. Along with highlighting the particular emphasis of military dependents in my school districts, I also want to bring to your attention problems that have developed with regard to implementation of the Gramm-Rudman-Hollings fiscal 1986 sequester.

My district is the home of Offutt Air Force Base and the headquarters of the Strategic Air Command. The presence of this large military installation creates an influx of residents in the surrounding communities and, concurrently, reduces local tax revenues that comprise a majority of the resources allocated for public education in Nebraska.

As crafted in 1950, the impact aid program was designed to provide payment-in-lieu of local property taxes for these military dependents. The impact aid program is a long-standing responsibility that the Federal Government must continue to support.

In addition, I would argue that in order to make the military attractive and to enable it to retain high-quality personnel, it is imperative that this "in-lieu-of-tax" payment—which is the mechanism used to provide free public education to the children of military personnel—continue to receive adequate funding.

Approximately 65 percent of the students in the Bellevue, Nebraska, public school system are federally connected. This school district is forced to assume a large financial burden and qualifies under Section 3(d)2(B) of the impact aid law. School districts qualifying under Section 3(d)2(B) have a Federal impaction of 50 percent or more and are unable to provide sufficient revenues from the local level. These districts should continue to be fully funded.

A second important consideration should be the funding of all "A" students. The burden these students place on a local school district is well recognized. In the case of continued limited resources, special attention must be given to full funding of those districts known as "Super-As" which have an impaction of at least 20 percent.

A third essential component of the impact aid program is continued appropriations for the military "B" students. In my district, many of the personnel from Offutt Air Force Base live in the civilian community. Although these communities consist primarily of "B" students, the school districts are also adversely affected by the military presence. Again, in light of limited resources, "Super B" districts with an impaction of at least 20 percent should be supported.

Certainly, I am fully aware of the fiscal constraints that this committee and all of us in Congress now face. In order to comply with our budget deficit targets, Federal spending must be done in a responsible manner, and priorities must be set which recognize our legitimate commitments.

Along these lines, I want to address specific concerns that have been brought to my attention with regard to maintaining priorities within the impact aid program.

Recognizing that the fiscal year 1986 impact aid appropriation was not adequate to fully fund all sections of the legislation, special provisions were placed in the appropriations bill for 1986 indicating that "Super A" districts were to be funded at 100 percent first, then all remaining "A" funds were to be distributed on a prorata basis. Also, "Super B" districts were to be prorated at 60 percent and all remaining "B" funds were to be distributed on a prorata basis.

The President's sequester, in accordance with Gramm-Rudman-Hollings, reduced the appropriation for impact aid. Even though the sequester order did not change the priority language for "Super A" and "Super B" districts, the Department of Education is proposing to implement the Gramm-Rudman reduction by reducing all payments by 4.3 percent—including those to "Super A" and "B" districts.

My purpose in bringing this matter to your attention, Mr. Chairman, at this time is to request the subcommittee's assistance in securing a proper interpretation for 1986 and to support the continuation of the priority funding for "Super A" and "B" districts as specified in the 1986 appropriation bill. It seems wise to assure that the limited funds which are available for impact aid go first to those districts which are highly federally impacted. These priorities ensure that these limited funds are made available first for those districts which are highly federally impacted.

Perhaps a letter by the subcommittee to Mr. Bennett might set the ball rolling beyond what could be done in committee action or legislation.

I am certain the committee is aware of the unpleasant alternatives that local school districts may realistically face without adequate funding support. I want to note the special case of Nebraska, where the State law requires that federally owned property be excluded from a school district if the Federal presence results in a local tax levy which exceeds the average of other schools systems of the same class in the county. In the event that adequate funding is not available to these severely impacted military districts, this statute would allow the State to create a separate school district for students residing in these communities near Offutt Air Force Base. These newly-created schools would then have to be supported by State or Federal funds, or a combination of both.

In closing, I would point out that throughout the years, Congress has continued to recognize the necessity of this program, and I am hopeful that this commitment to education of our young people will continue.

Again, thanks for the opportunity to appear before you today.

Mr. NATCHER. Thank you, Mr. Daub. You have given us an excellent statement. We appreciate your appearance before the committee. Mr. Bennett, we are glad to have you, and Dr. Deegan, we are glad to have you.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. HERBERT H. BATEMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. NATCHER. Our next witness is Mr. Herbert Bateman. Come around, Mr. Bateman. It is a pleasure to have you before the committee and we will be pleased to hear from you.

Mr. BATEMAN. Mr. Chairman, I have a prepared statement which I will not take up your time reading in full, and I would ask unanimous consent to submit the statement of Dr. Don Bruno, a constituent of mine, and the outgoing president of the National Association of Federally Impacted Schools.

[The statement of Mr. Bruno follows:]

STATEMENT TO THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR/HEALTH AND HUMAN SERVICES EDUCATION

by

MR. DON BRUNO

Mr. Chairman: Since 1981, the appropriation for impact aid has dropped to less than 50% of the amount needed to fully fund the impact aid law. If the actual financial obligations were met, $1.2 billion would be needed for impact aid. In FY85, the appropriation was only $675 million. Impact aid has already had more than its share of deficit reduction.

One problem with the current appropriation is the wide disparity in payments. Per pupil payments range from $23 to $1,430 of a $3,000 per pupil cost depending on the category. Regular "A" student payments are at 33% of Super "A" student payments- $472 per pupil compared to $1,430 per pupil. An effort needs to be made to achieve at least 70% of payment for the regular "A" students.

Another problem is the continued pressure to cut or eliminate "B" payments. The local taxing agencies of this nation are not permitted to tax federal property for the operation of schools. In addition to the federal government not paying property tax on federal property, the nation's uniformed personnel who live off base may avoid paying vehicle license and state income taxes that help support local education agencies. Impact aid for "B" as well as "A" students is revenue from the federal government to local education agencies for services rendered.

Three presidential commissions designed to discredit Impact Aid have actually resulted in findings endorsing the law. Impact Aid is a reasonable solution to a federally caused problem. Absorbing a federally connected child into the public school system is cheaper by as much as 50% than educating the same child in a military school.

Mr. BATEMAN. I appear, first, to thank and commend you for the leadership that you have shown in seeing that impact aid to our school systems in America was continued, and to offer my support, and that it be further continued in the future. This is an important ingredient to quality education, in a district such as mine, which has a number of very intensive Federal, military and other installations in it.

I represent a county which has some 90 percent of all of its land owned by the United States Government. Programs such as impact aid are vitally important to maintaining the responsibility of localities for quality education in our public schools.

It cannot be done without this assistance, and my statement seeks to point out the kind of impact that Federal presence has on school districts such as mine, and their diminishment of the tax base that would otherwise be in support of public education.

I thank the chairman for the opportunity to appear and to make a statement and to submit my written testimony for the record.

Mr. NATCHER. Thank you very much. We are delighted to have had you. You made an excellent statement and you come back to see us.

[The statement of Mr. Bateman follows:]

STATEMENT BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR/HEALTH AND HUMAN SERVICES/ EDUCATION

BY

THE HONORABLE
HERBERT H. BATEMAN

MR. CHAIRMAN: I WANT TO THANK YOU FOR HOLDING THIS HEARING TODAY TO DISCUSS FUNDING FOR THE IMPACT AID PROGRAM. IN ADDITION TO MY STATEMENT I WILL ALSO BE SUBMITTING A STATEMENT ON BEHALF OF MY CONSTITUENT, DON BRUNO, OUTGOING PRESIDENT OF THE NATIONAL ASSOCIATION OF FEDERALLY IMPACTED SCHOOLS.

THE FIRST CONGRESSIONAL DISTRICT OF VIRGINIA, WHICH I REPRESENT, PROVIDES A PERFECT EXAMPLE OF THE NEED FOR THE CONTINUED ADEQUATE FUNDING OF THE IMPACT AID PROGRAM. THE POPULATION CENTER OF MY DISTRICT LIES ON THE SOUTHERN END OF THE PENINSULA BETWEEN THE JAMES AND THE YORK RIVERS, AND CONSISTS OF THE CITIES OF HAMPTON, POQUOSON, NEWPORT NEWS AND YORK COUNTY. IN THIS FAIRLY SMALL GEOGRAPHIC AREA, I HAVE THE PRIVILEGE TO REPRESENT FORT EUSTIS, THE CENTER OF THE ARMY TRANSPORTATION COMMAND; FORT MONROE, THE CENTER OF THE ARMY TRAINING AND DOCTRINE COMMAND; LANGLEY FIELD, HOME OF BOTH THE TACTICAL AIR COMMAND AND A MAJOR NASA RESEARCH FACILITY, THE YORKTOWN NAVAL WEAPONS CENTER, A MAJOR COAST GUARD TRAINING FACILITY, AND I WILL SOON REPRESENT A MAJOR NEW DEPARTMENT OF ENERGY HIGH ENERGY PHYSICS LABORATORY, THE CONTINUOUS ELECTRON BEAM ACCELERATOR FACILITY.

THESE FACILITIES IN CONJUNCTION WITH NEWPORT NEWS SHIPBUILDING AND DRYDOCK COMPANY, PROVIDE THE ECONOMIC BACKBONE OF THE NORTH HAMPTON ROADS AREA, AND ARE VITAL AND WELCOME ADDITIONS

TO OUR COMMUNITY. HOWEVER, WHILE PROVIDING A LARGE DEGREE OF FINANCIAL STABILITY TO THE AREA, THESE FACILITIES ALSO POSE SERIOUS FINANCIAL PROBLEMS FOR LOCAL GOVERNMENTS.

WHEREAS NEWPORT NEWS SHIPBUILDING EMPLOYS NEARLY 30,000 PEOPLE AND PAYS MILLIONS OF DOLLARS IN LOCAL TAXES, THE GOVERNMENT INSTALLATIONS WHICH I LISTED EMPLOY ROUGHLY THE SAME NUMBER OF PEOPLE AND PAY NO LOCAL TAXES.

LOCAL GOVERNMENTS DERIVE THE BULK OF THEIR REVENUE FROM PROPERTY AND SALES TAXES, BUT MANY MILITARY PERSONNEL WORK AND LIVE ON NON-TAXABLE FEDERAL PROPERTY. EVEN IF THEY LIVE OFF BASE, THEY ARE ALLOWED TO ESCAPE LOCAL TAXES ON THEIR CARS AND OTHER VEHICLES, AND BOTH ACTIVE AND RETIRED MILITARY SHOP IN THE SALES-TAX EXEMPT POST-EXCHANGES. THIS DENIES LOCALITIES REVENUES ON WHAT WOULD OTHERWISE BE TAXABLE COMMERCIAL AND RESIDENTIAL PROPERTY, AND TAXABLE COMMERCIAL SALES. DESPITE THIS SEVERE EROSION OF THE LOCAL TAX BASE, LOCALITIES MUST STILL PROVIDE SERVICES TO THE MILITARY FAMILIES THAT LIVE IN THEIR COMMUNITIES, AND NOT THE LEAST OF THOSE SERVICES IS A FREE PUBLIC EDUCATION.

LOCAL GOVERNMENT ALSO LOSES REVENUE ON THE LARGE FEDERAL CIVILIAN WORKFORCE WHO PAY PERSONAL PROPERTY AND SALES TAXES, BUT WHOSE PLACE OF BUSINESS ESCAPES TAXATION.

IN AN EFFORT TO HELP TO ALLEVIATE THE FISCAL BURDENS PLACED ON AREAS LIKE HAMPTON ROADS BY THE FEDERAL PRESENCE, CONGRESS CREATED THE IMPACT AID PROGRAM IN 1950. THIS PROGRAM HAS PROVIDED ESSENTIAL PAYMENTS TO LOCAL SCHOOL DISTRICTS TO MAKE UP FOR LOST

TAX REVENUES, AND TO ALLOW THESE COMMUNITIES TO PROVIDE THE SORT OF QUALITY EDUCATION WHICH BOTH LOCAL STUDENTS AND THE CHILDREN OF MEMBERS OF THE ARMED SERVICES DESERVE.

UNFORTUNATELY, THE PROGRAM, ESPECIALLY 3 (B) PAYMENTS, HAS NEVER BEEN POPULAR WITH FEDERAL BUDGET CUTTERS, AND AS FEDERAL SPENDING HAS GOTTEN TIGHTER AND TIGHTER IMPACT AID HAS BEEN ATTACKED AGAIN AND AGAIN. IN 1981 WHEN CONGRESS PASSED THE BUDGET RECONCILIATION ACT A DECISION WAS MADE TO ELIMINATE THE CATEGORY 3 (B) PAYMENTS, PAYMENTS FOR STUDENTS WHOSE PARENTS LIVE OR WORK ON FEDERAL PROPERTY, BY FISCAL YEAR 1984. FORTUNATELY, WE REVERSED THAT POSITION LATER AND REAUTHORIZED B PAYMENTS THROUGH FISCAL YEAR 1988.

DESPITE THE CONGRESSIONAL SUPPORT FOR CONTINUED (B) PAYMENTS, THE ADMINISTRATION CONTINUES TO OPPOSE THOSE PAYMENTS, AND THE ADMINISTRATION'S FISCAL YEAR 1987 BUDGET AGAIN CALLS FOR NO (B) PAYMENTS. THIS WOULD SAVE THE FEDERAL GOVERNMENT $130 MILLION--BUT AT WHAT COST TO THE EDUCATION OF OUR CHILDREN?

THE IMPACT AID PROGRAM IS FUNDED AT ONLY ABOUT HALF OF WHAT IT WOULD COST TO IMPLEMENT THE PROGRAM AT FULL ENTITLEMENT, AND SINCE 1980 HAS LOST MORE THAN 36% IN VALUE. I URGE THE COMMITTEE TO FUND IMPACT AID AS CLOSE TO THE $780 MILLION AUTHORIZATION LIMIT AS POSSIBLE, AND CERTAINLY NO LOWER A LEVEL THAN THE $675 MILLION PROVIDED IN FISCAL YEARS 1985 AND 1986.

TUESDAY, MAY 16, 1986.

IMPACT AID

WITNESS

HON. HARRY REID, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEVADA

Mr. NATCHER. Our next witness is Mr. Harry Reid. We will be pleased to hear from you, Mr. Reid.

Mr. REID. Thank you for allowing me to testify before you today. Holding hearings on the important issue of appropriation for programs provided by Public Law 81-874, popularly known as impact aid, will serve to focus public and Congressional attention to three issues. First, the role this program plays in financing the operations of school districts around the Nation.

Second, the effect the Reagan Administration's budget proposals would have upon this program and the quality of education. And third, how this program should be structured in the future.

As in many other areas of the country, impact aid plays a critical role in financing public education in Nevada. In Clark County, which is essentially the First Congressional District, there is only one unified school district: Clark County School District, the 19th largest in the Nation by enrollment, serving 91,569 students.

Within and near Clark County lies Nellis Air Force Base, the Nuclear Test Site, an Indian reservation, a National Forest, and many smaller Federal facilities that have an impact on enrollment and the tax base in the Clark County School District. Together, personnel at these facilities contributed 12,743 students to the Clark County School District's student population for the academic year of 1984. Of course, by now it has gone up considerably.

The Clark County School District provides high quality education for 1,921 "A" students and 10,822 "B" students. These children, like their non-impact aid schoolmates, deserve the best education their elders can provide. However, quality education does not come cheap. Last year, the cost of educating a child averaged $3,000 a year nationwide. In the Clark County School District the cost for educating a child is $2,600 per year. In other words, the Clark County School District paid $33,131,800 to educate the impact aid children it is required by law and the standards of a compassionate and civilized society to educate.

Impact aid provided $1,305,276 last year to defray the costs of educating these children. Although this amount represents only 4 percent of the total cost of educating these children, were this money unavailable or substantially reduced the Clark County School District would be faced with the dilemma of either reducing programs and lowering standards, or refusing to enroll the children. Neither option is desirable.

This scenario is admittedly quite bleak, one that I am confident the Congress will not allow to occur. However, the administration's budget would severely weaken this program. The administration, by proposing to eliminate funding for the "B" category of children proposes to abrogate a 350-year commitment not only to school districts trying their utmost to provide education to all comers, but also to servicemen and their employees of the Federal Government who make innumerable sacrifices in order to serve their country. These men and women deserve better than to have the future of their children cast in doubt in order to validate some economic theory.

The administration also proposes to severely curtail Section 7 of Public Law 81-74, the provision authorizing disaster assistance to school districts. This proposal has simply not been well considered, or was suggested by someone unfamiliar with the devastating effects of a natural disaster. Earlier this year, heavy rains caused flash flooding in northern Nevada. Damage was extensive, but could easily have been much greater.

Suppose a school had been swept away or destroyed by the floodwaters? Under current law, funds would become available in quantities sufficient to continue operations and rebuild lost and damaged facilities. Under the administration's proposal, funding for operations would be severely cut back, while money for repairs and construction would be completely eliminated.

My feelings, Mr. Chairman, regarding these proposals are unequivocal; they are, like much of the rest of the rejected administration budget, unrealistic and unacceptable. I hope the subcommittee will give these two proposals all the consideration they deserve—none.

When the subcommittee marks up the impact aid appropriation for fiscal year 1987, I hope the subcommittee will come forward with the following bill. Funding must, at the very least, be maintained at the pre-sequestration fiscal year 1986 appropriation level, preferably with an allowance made for inflation. The President's proposal to eliminate funding for Section 3(b) payments and Section 7 disaster relief funds must not be included. And a new formula for the distribution of funds, which does not subject a district to monetary losses inconsistent with losses in enrollment of subject children, should be considered.

Mr. Chairman, although I am not concerned with labels, within the Democratic Party I am often referred to as a moderate. However, I am not moderate in my support of education programs at all level, both public and private. The unprecedented and unwarranted attack upon our Nation's public schools, a hallmark of this administration must be decisively halted this year. Particularly onerous is this attack upon a law that enables local school districts to serve every student eligible to attend public school. Is this a program that is moderate? The answer is no.

Mr. Chairman, I support a strong defense as well. However, I believe a strong defense is dependent upon a well-educated populace. Furthermore, a strong defense is not one that requires a nation to sacrifice the very values that it deems worthy to defend. Who wants to defend a nation of illiterates?

Finally, Mr. Chairman, I believe that the goals of fiscal restraint, a quality education, and a strong defense are compatible. In fact, they are complementary. I hope you and the rest of the subcommittee will keep this thought in mind when you mark up appropriations for Public Law 81-874 and other education programs for fiscal year 1987.

Thank you.

Mr. NATCHER. Thank you very much, Mr. Reid. You have given us an excellent statement, and we appreciate your appearance.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. DAVID O'B. MARTIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. NATCHER. Mr. Martin, we will be glad to hear from you at this time.

Mr. MARTIN. Thank you for once again allowing me to come back to offer testimony. You have been very kind to me. This is the sixth year I have testified in support of impact aid.

There is not an awful lot more I could say than I have in past years concerning impact aid, and I know you feel the same way. My predecessor talked about Nellis Air Force Base; whether it be Nellis, Fort Drum or whatever military installation we have throughout the country, we have to assure that if we are going to keep a close working relationship between the people in uniform and the civilian community, we have to insure that in fact there is not a burden on the local taxpayer in attempting to provide quality education and, almost as important, insure that we don't have any perceived burden on the local taxpayer as we attempt to provide the best education possible.

This goes for the "B" students as well. We understand it is just not totally the burden of a local property owner, in the various States, counties and school districts, but also the income tax structure in the various States, that supports education as well. Often you have uniformed personnel who are not paying those kinds of taxes, and that was the purpose of this program at the very outset.

I hope the chairman is successful, as he has been in the past.

Understanding that this is the sixth year I have testified, and we have fought this battle over and over again, you have been the champion, Mr. Chairman, and I am satisfied you will carry the torch once more for us.

Thank you very much for your time and attention. With that, I will submit my statement.

Mr. NATCHER. We apppreciate your appearance.

[The statement of Mr. Martin follows:]

Statement of the

Honorable David O'B. Martin

26th District, New York

Before the
Subcommittee on Labor-Health and Human Services-Education
House Committee on Appropriations

May 6, 1986

Mr. Chairman, my presence before your panel today is an all-too-familiar scene, as each year those of us with military installations in our Congressional Districts come before you to urge retention of funding for the all important Impact Aid Program. Once again, I am here to express my support for the program, and to urge that reimbursement continue to be made to all school districts charged with educating the dependent children of our military personnel.

I have told you many times of the fine spirit of cooperation which exists between my Northern New York communities and the military establishments at Fort Drum and Plattsburgh Air Force Base. This is the situation not only in my District but, I am sure, in all areas of our nation where military and civilian communities co-exist. These communities recognize the need for a strong military establishment and are more than willing to cooperate with the military in any reasonable way. Mr. Chairman, I know you agree with me that the Impact Aid program is an important ingredient in maintaining this cohesiveness, just as I know you share my belief that the relationship must continue to be fostered and nurtured. We must continue funding this program in order to ensure that there is no perceived burden on the local school district through educating the dependent children of our military personnel.

In past testimony, I have expressed my concern that full payments be provided for educating "A" students. I reiterate that concern today. As you are well aware, the sponsors of these students reside on base and pay no local school taxes. It is inherently unfair to expect the civilian community to educate their children without any financial assistance. And, unless the sponsor is a legal resident of the state, the sponsor contributes nothing to the educational system at the state level. Payment of taxes to another state provides no consolation to local taxpayers. In rural areas where total school populations are relatively low, it is essential that full payments be maintained in order to support a full curriculum and to avoid intolerable increases in local taxes. The distribution of Impact Aid funds on behalf of these students must be based solely on a set, per-pupil amount.

I also believe, Mr. Chairman, that there is justification for assistance to local school districts on behalf of "B" students. As you well know, the financial impact on these communities is real, though obviously not to the extent it is felt by virtue of educating "A" students.

Funding for the construction and renovation of school facilities must also be carefully considered. With its sole purpose being the provision of construction money for minimum school facilities in districts where the ability to generate tax revenue for capital improvements is affected by Federal ownership of non-taxable properties, this is an important program to many communities acrcss the country.

In closing, Mr. Chairman, let me again stress the importance of maintaining the outstanding civilian-military relationships which currently exist. If funding for the Impact Aid program is not continued, and at a level sufficient to offset some of the impact of educating these children, tensions will rise and these relationships will become strained. While I am all too aware of the budget constraints we face in crafting a Fiscal Year 1987 budget, I hope and trust we can see our way clear to do the right thing.

Your patience is appreciated, Mr. Chairman, and I thank you once again for permitting me this opportunity to express my views on this valuable program. As in the past, I am sure that through your strong and able leadership we will be successful again this year.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESSES

HON. JAMES S. ABDNOR, A U.S. SENATOR IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

HON. LARRY PRESSLER, A U.S. SENATOR IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

GLENN BARNES, SUPERINTENDENT OF SCHOOLS, TODD COUNTY, SOUTH DAKOTA, AND PRESIDENT, SOUTH DAKOTA IMPACT SCHOOLS

DONALD MUELLER, SUPERINTENDENT OF SCHOOLS, DOUGLAS SCHOOL SYSTEM, ELLSWORTH AIR FORCE BASE, SOUTH DAKOTA

Mr. NATCHER. Our next two witnesses are our friends from South Dakota, Senator Abdnor and Senator Pressler. Gentlemen, come around.

These two gentlemen started out in the House. They received good training in the House and then they decided to go to the Senate. We will be pleased to hear from you.

Senator ABDNOR. Thank you, Mr. Chairman. I am flattered that you remember us so well, because we feel very close to the House. Often you, my good friend, Congressman Conte, and I meet in appropriations conferences. Although we sometimes differ on certain subjects, we always come out very well.

With me today besides Senator Pressler are two school superintendents from South Dakota, who are well-versed on the subject matter we are talking about today. On my left is Glenn Barnes, Superintendent of the Todd County School, South Dakota, and President of the South Dakota Impact Schools. And on my right's Dr. Donald Mueller, Superintendent of the Douglas Schools System, Ellsworth Air Force Base, I am particularly pleased that these two gentlemen could join us because they represent two very important elements of the impact aid program.

Mr. Barnes, represents a county in South Dakota—correct me if I am wrong, Glenn—in which almost two-thirds of the land is untaxable under Federal law. Almost 80 percent of the students enrolled in the county schools are Indian students who reside on the large reservation nearby.

On my right, Dr. Mueller, Superintendent of the district on the SAC base, Ellsworth—a base we are very proud of, a very important base, which is being enlarged to house 2 squadrons of the B-1 bomber, which will increase enrollment—relies heavily on impact aid funds to provide for his students, almost 80 percent of whom are military dependents.

I appreciate the opportunity to appear before this subcommittee to discuss the funding needs of our Nation's federally impacted schools. I have been an outspoken proponent of impact aid programs since coming to Washington in 1973 as a Member of the House.

Perhaps my vigilance on this subject can be attributed to the closing of the Douglas School System at the Ellsworth Air Force Base that same year. I learned firsthand what can happen to a heavily impacted school district when it fails to receive adequate Federal support. Given that experience, Mr. Chairman, I am committed to preventing a recurrence.

Mr. Chairman, I find myself confronted with an unusual yet most welcome situation this year as we work to develop a budget for fiscal year 1987. Although the administration's budget proposal is a repeat of those that preceded it, I am pleased to report that the budget package approved last week by the Senate provides the fiscal year 1986 appropriation level—before the 4.3 percent sequester—with an adjustment for inflation—for education programs, including impact aid. I was pleased to cosponsor the successful floor amendment which provides an additional $1,200,000,000 for vital education programs in the coming fiscal year.

I believe the Senate's action bodes well for the upcoming fiscal year 1987 appropriations process, Mr. Chairman. No doubt this subcommittee's task will prove less difficult if the final budget package approved by Congress reflects the priority for education programs established in the Senate plan.

I know these are difficult times in the farming areas of our Nation. In my own State, property values have dropped, threatening the financial stability of local school districts. More than 20 South Dakota school systems are so-called Super A districts, with enrollments comprised of 20 percent or more A children. With one exception, these school districts are responsible for educating Native American children who reside on tax-exempt land. In the other, the children are military dependents whose parents both live and work on the air base.

It is particularly difficult for these heavily impacted districts—which depend upon Public Law 81-874 for a large portion of their budgets—to cope with reductions in their impact aid payments. And when Federal funds are reduced severely impacted schools find it more difficult—if not impossible—to compensate for the loss by raising revenues from local sources due to the minimal tax base available. It is important to note that some of these districts are already taxing at the maximum mill levy permitted by State law. Additionally, several of these schools are located in some of the poorest counties in our Nation.

Mr. Chairman, I have been pleased to lead the fight in the Senate to bring back to a respectable level support for federally impacted schools. The Omnibus Budget Reconciliation Act of 1981 reduced funding for impact aid more than 40 percent, compared to a 7 to 10 percent reduction in other education programs. The impact aid program sustained a disproportionate share of reduction, yet it is the program upon which federally affected schools depend to put a chair under the child and a book in his hand.

Important as our Federal categorical programs are, they are not needed to pay the electric bill and the janitors. Impact aid is intended to compensate local school districts for the revenues lost due to Federal activity. It is used to provide children with a basic education.

I am happy to have played a part in restoring a portion of the hefty cut in impact aid. With the chairman's help, we restored $110,000,000 in fiscal year 1984 appropriations and another $110,000,000 in fiscal year 1985, and we saved Category B payments—of special significance to the chairman's district—from extinction.

We now have a streamlined program, funded well below the authorization ceiling. Although I am not a member of the Senate subcommittee which works so closely with this subcommittee, I am a Member of the full Senate Appropriations Committee and I am pleased to work closely with the distinguished chairman of the Senate subcommittee, Senator Weicker. Further, I often serve as a conferee on continuing resolutions and supplemental appropriations measures and, as such, have had the opportunity to work with you, Mr. Chairman.

While we may differ from time to time on the way in which available funds should be distributed, I know that you share my interest in providing sufficient assistance to federally impacted schools—through both Public Law 81-874 and Public Law 81-815. Almost one year ago today I was sending thank you notes to the 46 senators who joined me in support of an amendment to the Senate budget resolution—which failed by two votes—to restore support for Category B payments to the fiscal year 1985 appropriations level.

Today, given the recent budget action taken by the Senate, I am pleased to note that the outlook for this program appears brighter.

Mr. Chairman, Members of the Committee, I ask that an April 15 letter I wrote to Secretary Bennett, signed by the South Dakota Congressional Delegation, concerning the Douglas School System, be included in the hearing record.

Mr. Chairman, I thank you for the opportunity to share with you my views on funding for this vital program, and I look forward to continuing to work with you, Congressman Conte, and your subcommittee colleagues as Congress continues to develop budgetary priorities for the coming fiscal year.

Thank you very much, Mr. Chairman.

Mr. NATCHER. Thank you very much, Senator Abdnor. You have given us an excellent statement.

Mr. NATCHER. Senator Pressler, we will be pleased to hear from you.

Senator PRESSLER. I am pleased to have this opportunity and I thank you very much for your time. I ask unanimous consent to insert my statement in the record. It covers many of the same points that Senator Abdnor has covered so well. I want to yield some of my time to Mr. Miller and Mr. Barnes, and say that my statement covers our division of A and B schools and our new problems with the B-1 bomber, and the 600 new military families who are coming.

I talk about the pre-Gramm-Rudman levels, and the action of the Senate Budget Committee. I just want to say briefly that I also have some legislation which we call the Strategic Defense Education Act, which is somewhat similar to the National Defense Education Act of 1947, and I think this is relevant in this issue I believe that education is an integral part of national defense, and if we have the Strategic Defense Initiative, or some form of it—and I am somewhat skeptical about it.

But if we do have it, we may not have people to operate it in our primary schools, our secondary schools, and particularly our colleges. We are finding half of our engineering students are from abroad and many of our high schools are not able to carry some of the math and science that we need, and this impact aid is related to it. It is giving education a priority, and I know this subcommittee has given that priority, I thank you for that.

I will yield the time allotted to me to two of our superintendents and I ask unanimous consent to place my statement in the record.

Mr. NATCHER. Without objection.

[The statement of Senator Pressler follows:]

STATEMENT OF SENATOR LARRY PRESSLER
BEFORE THE
LABOR, HHS, EDUCATION AND RELATED AGENCIES
APPROPRIATIONS SUBCOMMITTEE
ON THE IMPACT AID PROGRAM
MAY 6, 1986

MR. CHAIRMAN, I WANT TO COMMEND YOU FOR HOLDING THIS HEARING ON THE IMPACT AID PROGRAM. I AM PLEASED TO BE ABLE TO TESTIFY BEFORE THIS SUBCOMMITTEE TODAY ON BEHALF OF 42 SOUTH DAKOTA SCHOOL DISTRICTS WHICH RELY ON IMPACT AID FUNDING TO EDUCATE OVER 11,000 FEDERALLY-CONNECTED CHILDREN.

MANY SOUTH DAKOTA SCHOOL DISTRICTS RELY HEAVILY ON IMPACT AID APPROPRIATIONS TO KEEP THEIR DOORS OPEN. SOUTH DAKOTA HAS A PARTICULARLY LARGE NUMBER OF SCHOOLS LOCATED ON OR NEAR INDIAN RESERVATIONS WITH LARGE INDIAN POPULATIONS. OVER HALF OF OUR 42 IMPACTED DISTRICTS ARE "HEAVILY IMPACTED," WITH 20 SUPER A DISTRICTS AND THREE SUPER B DISTRICTS. ADDITIONALLY, NEARLY 80 PERCENT OF THE CHILDREN EDUCATED IN THE DOUGLAS SCHOOLS SYSTEM LOCATED ON ELLSWORTH AIR FORCE BASE NEAR RAPID CITY, SOUTH DAKOTA, ARE MILITARY DEPENDENTS. 600 TO 750 NEW MILITARY FAMILIES ARE EXPECTED AT ELLSWORTH DUE TO THE PHASE IN OF THE B-1 BOMBER PROGRAM.

MR. CHAIRMAN, THE FIRST AND MOST IMPORTANT POINT I STRESS IS THAT THE EDUCATION OF OUR YOUTH HAS GOT TO BE A TOP PRIORITY FOR THIS NATION. FUNDING FOR EDUCATION PROGRAMS IS A WISE INVESTMENT

IN OUR FUTURE. IT AFFECTS OUR PRODUCTIVITY, OUR ECONOMIC COMPETITIVENESS, AND OUR NATIONAL SECURITY. THE IMPACT AID PROGRAM RECOGNIZES A BASIC RESPONSIBILITY OF THE FEDERAL GOVERNMENT TO COMPENSATE FOR LOST REVENUE RESULTING FROM FEDERAL ACTIVITY OR OWNERSHIP.

HOWEVER, DEFICIT REDUCTION MUST ALSO BE A TOP PRIORITY. SO, WE IN CONGRESS ARE FACED WITH DIFFICULT CHOICES. WE MUST DECIDE WHICH PROGRAMS SHOULD BE REDUCED OR ELIMINATED. MANY OF THE EDUCATION PROGRAMS, INCLUDING IMPACT AID HAVE ALREADY BEEN CUT TO THE BONE IN PAST YEARS. FURTHER CUTS THREATEN THEIR VERY SURVIVAL.

I AM PLEASED THAT THE SENATE RECENTLY TOOK A STEP CONFIRMING THIS COMMITMENT TO EDUCATION. DURING CONSIDERATION OF THE FISCAL YEAR 1987 BUDGET RESOLUTION, WE ADOPTED AN AMENDMENT RESTORING SOME $1.2 BILLION TO EDUCATION PROGRAMS. I WAS A COSPONSOR OF THIS AMENDMENT. THE SUBSTITUTE PACKAGE WHICH WE PASSED, INCLUDES THIS AMENDMENT, AND INCEASES FUNDING IN FUNCTION 500 BY NEARLY $4 BILLION OVER THE ORIGINAL RECOMMENDATION OF THE BUDGET COMMITTEE. ACCORDING TO BUDGET COMMITTEE STAFF, THE IMPACT AID PROGRAM IS FUNDED AT THE PRE-GRAMM-RUDMAN FISCAL YEAR 1986 APPROPRIATION, PLUS AN INFLATION ADJUSTMENT. I AM SURE YOU WILL AGREE, MR. CHAIRMAN, THAT THIS IS, INDEED, A STEP IN THE RIGHT DIRECTION.

More specifically, two sections of the Impact Aid program have been particularly threatened: Category "B" students and funding under Public Law 81-815, School Construction. While the Senate has taken the first step to continue funding for these programs, we still have a long way to go. The "Bs" have been threatened with elimination for several years, and a drastic reduction in the already underfunded Construction program has been recommended.

The President's Fiscal Year 1987 Budget request recommended funding of $5 million for Construction -- down from $23 million. Let me use an example in South Dakota to illustrate the need for 815 funding. In Todd County, which is 80% impacted, a new Middle School is needed. Due to an increased retention rate and high Indian birth rates, their enrollment is projected to increase from 1,825 students in 1986 to 2,300 or 2,400 students in 1990. They face an immediate increase of 175 students next year. A new Middle School is estimated to cost nearly $4 million. With only $5 million in funding for Construction, only one or two projects could receive funding nationwide. I know there are many school districts across the nation which face a situation similar to that of Todd County Schools.

In closing, Mr. Chairman, I recommend a funding level at least equal to the pre-Gramm-Rudman appropriations in FY 86. Elimination of Category "B" funding and sharp reductions in

CONSTRUCTION WOULD DRAMATICALLY IMPACT OUR ALREADY "IMPACTED" SCHOOL DISTRICTS.

I ALSO WANT TO THANK GLENN BARNES OF SOUTH DAKOTA, WHO WORKS SO DILIGENTLY ON BEHALF OF SOUTH DAKOTA'S IMPACTED SCHOOL DISTRICTS. I HAVE WORKED WITH GLENN FOR MANY YEARS, AND GREATLY APPRECIATE HIS CONTINUED ADVICE AND LEADERSHIP ON THIS ISSUE.

JAMES ABDNOR
South Dakota

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April 15, 1986

The Honorable William Bennett
Secretary
Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202

Dear Mr. Secretary:

We seek your assistance to ensure the financial stability of the Douglas School System, Ellsworth Air Force Base, South Dakota, which is responsible for educating military dependents.

Children of military personnel comprise nearly 80 percent of the school system's total enrollment. An influx of 600 to 750 new military families is anticipated over the next couple of years due to the phase-in of the B1 bomber program.

Short of a DOD Section 6 arrangement, this school district is in need of adequate impact aid funding through Section 3(d)(2)(B) of P.L. 81-874. In 1984, Congress adopted several special impact aid provisions, including an amendment designed to preclude a proration of payments to Section 3(d)(2)(B) eligible districts. Unfortunately, we are advised the department intends to prorate the district's FY86 regular Section 3 payment (pursuant to Gramm-Rudman-Hollings) and base its 3(d)(2)(B) payment on what the district is entitled to receive, versus what it is actually paid under Section 3(a) and 3(b). We believe this is contrary to Congressional intent. Additionally, the limitations placed on 3(d)(2)(B) payments through the use of a "maximum entitlement" cap, does not enable Douglas and other similarly situated school districts to provide a comparable level of education for **all** their students.

We are pleased to learn that the NPRM (Notice of Proposed Rulemaking) drafted by the Division of Impact Aid would alter the current method of computing "maximum entitlement" under 3(d)(2)(B) by utilizing a simple head count of federally connected students as opposed to applying a lesser weight for category 'B' children, vis-a-vis the so-called Goodling amendment included in the Omnibus Reconciliation Act of 1981 (P.L. 97-35). We are advised that the department plans to publish the NPRM in June with final regulations scheduled to take effect in FY87.

Mr. Secretary, this interpretation of Section 3(d)(2)(B) would help to ensure the long-term financial stability of the Douglas School System -- a school system which has been forced to close its doors in prior years. We are further advised that the draft NPRM includes language which will prevent districts that are not making a reasonable tax effort from receiving a windfall under the section, a safeguard we wholeheartedly endorse.

The children of those stationed at the SAC (Strategic Air Command) installation in South Dakota, deserve a quality education. The local school system which serves these children continues to make every effort to provide an excellent educational program. Thus, we ask that you reconsider the treatment of 3(d)(2)(B) eligible districts under Gramm-Rudman-Hollings in FY86 and give favorable consideration to the NPRM drafted by the Division which will assist the district and others like it in meeting the needs of their students.

We look forward to your reply.

Sincerely,

Larry Pressler — Jim Abdnor — Thomas A. Daschle

Larry Pressler, U.S.S. — James Abdnor, U.S.S. — Tom Daschle, M.C.

Mr. **Natcher**. Would you like to be heard?

Mr. **Mueller**. As superintendent of a district which has closed twice in the last 11 years—and I might add, that is looking at that possibility again next year. Without a high level of funding, without a different type of interpretation of the impact aid program by the Department of Education, we are looking at that possibility again. So I would encourage whatever support you have to maintaining the high level of funding so we do have a chance to survive.

Mr. **Natcher**. Thank you very much, Mr. Mueller.

Mr. Barnes, would you like to say a word?

Mr. **Barnes**. Only to publicly thank Senator Abdnor and Senator Pressler for their fine support of impact aid in past years, and also the support, Mr. Chairman, that you have given impact aid.

Mr. **Natcher**. Thank you very much, gentlemen. We appreciate your appearing before our committee

Mr. **Conte**. Mr. Chairman, I want to let those two superintendents know how lucky they are. Mr. Mueller and Mr. Barnes, you are ably represented in South Dakota. You have two of the finest senators that we have in the United States Senate. They really work for South Dakota.

Senator **Abdnor**. Thank you very much.

Senator **Pressler**. Coming from a baseball coach, that means a lot.

Tuesday, May 6, 1986.

IMPACT AID

WITNESSES

HON. JIM SAXTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

CLINTON R. MILLER, SUPERINTENDENT, NORTH HANOVER TOWNSHIP SCHOOLS

Mr. **Natcher**. Our next witness is our friend and colleague from New Jersey, Mr. Saxton.

Mr. **Saxton**. Thank you, Mr. Chairman. I appreciate the opportunity to appear before the subcommittee today. With me is Clint Miller, Superintendent of North Hanover Township Schools. Mr. Miller is keenly interested in the work of this subcommittee, as 77 percent of his schools' students are dependents of military personnel stationed at McGuire Air Force Base.

Obviously, any reduction in impact aid payments has a dramatic effect on the non-military families of Mr. Miller's school district. Because such a high percentage of North Hanover students are military dependents, a reduction in impact aid of only a small percentage results in a large dollar loss to the school district.

The locality would then be in the unenviable position of raising property taxes, or cutting back on educational services. This, in turn, would put a strain on the relationship between military bases and permanent residents.

Mr. Chairman, opponents of impact aid must not realize that parents of Category A students avoid contributing anything toward the cost of educating their children. These parents live in not-taxable homes, work in non-taxable buildings, and shop for non-taxable goods in commissaries.

We certainly cannot begrudge servicemen these privileges. After all, they defend the freedoms all of us enjoy. And since they are willing to fight to protect all of us, it is important that all of us, through the Federal Government, contribute a fair share toward the education of their children.

It is simply unfair to force local taxpayers to shoulder an increasingly large share of this cost. This is particularly true when a locality has a limited tax base because of the Federal presence.

The situation at North Hanover is by no means unique. Hundreds of school boards rely heavily on Category A impact aid, including Northern Burlington Regional (28 percent A, 6 percent B), Pemberton Township (24 percent A, 18 percent B), and Lakehurst Borough (32 percent A, 5 percent B) in or near my Congressional district.

Category B impact aid is just as much an obligation of the Federal Government as the A program.

I realize the B category is annually targeted for elimination, but that is unfair. It is indeed unfortunate that opponents of the B program do not understand that these families, while contributing some revenue toward the education of their children, are prevented from paying their full share by the Federal presence. For example, while B families may pay property taxes on their homes, their employers at the military base pay no taxes.

And either the Federal Government or the local taxpayer has to make up the difference. Certainly, this burden should fall to the Federal Government for all the reasons previously discussed.

Many school districts receiving Category B payments seem to expect elimination of the program. But the program can and should be revived.

There are seven other school boards in or near my district which receive B payments: Hainesport, Lumberton, New Hanover, Southhampton, Willingboro, Lakewood, and Toms River. They are all hoping that the Federal Government continues to meet its obligation to the B program.

Mr. Chairman, I am proud to have three military facilities located in my Congressional district. All contribute greatly to the national defense. But it is indeed frustrating for school boards, which educate the children of those who live and work on these bases, to have to fight for a "percentage of entitlement."

It is time for Congress to realize that impact aid is not a handout. Impact aid is simply payment for services rendered.

Finally, I should point out that federally impacted schools recently received good news from the Senate. The Senate's budget package provides for impact aid at 1985 levels, plus an inflationary increase. I will work toward passage of a budget in the House which includes this same language.

Of course, a budget resolution is not binding. Therefore, it is of the utmost importance that the Appropriations Committee fight for a full appropriation of these funds. To that end, your assistance, Mr. Chairman, would be greatly appreciated.

On behalf of Mr. Miller, I thank you again for the opportunity to appear before the subcommittee, and other school superintendents in my district, and families of those kids around the country who are affected also thank you. I thank you again for the opportunity to appear before this subcommittee If I may turn to Mr. Miller, he has a very, very short statement to make.

Mr. NATCHER. Thank you very much, Mr. Saxton. Mr. Miller.

Mr. MILLER. Thank you very much for the opportunity to be here. My major concern with a highly impacted school district of almost 80 percent is with the children that I am responsible for as far as their education. I am concerned with programs and class sizes, and this type of thing that I would have to cut if the impact aid program is curtailed in any way, shape or form. So I appreciate your help in keeping a great program going.

Mr. NATCHER. Thank you, Mr. Miller. Gentlemen, thank you very much.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. DANIEL K. AKAKA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF HAWAII

Mr. NATCHER. We now have six witnesses here to testify. Mr. Akaka, you come first. Mr. Whitley, come around; Mr. Morrison, come around; Mr. Swift, come around; and Mr. Dicks and Mr. Panetta. Have these six chairs here at the table. That will expedite the hearings up to this point.

Mr. Akaka, you will lead off; Mr. Whitley, you will be next; Mr. Morrison, Mr. Dicks, and Mr. Panetta, we will hear you in that order, and Mr. English, come around. We want to say to you quite frankly, we appreciate your assistance when we bring our bill out. You gentlemen help us, and we appreciate it. Gentlemen, we will be glad to hear from you.

Mr. Akaka.

Mr. AKAKA. Thank you very much, Mr. Chairman and Mr. Conte. In representing the interests of both Hawaii and the people of this nation, I want to express my concerns on two subjects being considered by the subcommittee—impact aid and the medical officer training program for Micronesia and American Samoa. It is hoped that the information provided will assist the subcommittee in its deliberation of the Labor, Health and Human Services, and Education Appropriations Bill for the 1987 fiscal year.

As a former teacher and administrator in Hawaii's public school system and as a Member of the House Appropriations Committee, I certainly appreciate the subcommittee's efforts to respond to the educational needs of my State. In particular, I appreciate the attention that this subcommittee has given to the impact aid program and to Hawaii's unique situation as the only State with a single statewide school district. The administration's efforts to make severe reductions in impact aid funding will place a tremendous burden upon public school systems which rely upon the compensatory relief provided by impact aid.

The State of Hawaii received $9,100,000 in impact aid for both fiscal year 1985 and fiscal year 1986 pre-sequestration. This amount was not spent on supplementary programs; rather, impact aid funding was used to cover the cost of providing regular instruction to federally connected students. Impact aid compensated the State for the burden imposed upon its public school system to educate Hawaii's share of approximately 39,000 federally connected students.

These federally connected students constitute nearly 24 percent of the total public school enrollment in Hawaii. I have been advised that the administration's proposals for fiscal year 1987 would reduce this amount to $8,500,000, a cut which comes at a time when many schools within the system are having a difficult time meeting the educational needs of their students.

In effect, this cutback will force Hawaii to absorb a substantial tax revenue loss and service burden associated with Federal activities in the State.

In comparison with the astronomical figures we deal with in our Appropriations Committee, a loss of nearly $600,000 seems nominal at best. But the effect on my State is real—a loss of 22 full-time teachers directly attributed to the elimination of Category B payments, and a loss in funding for 16 teachers from impact aid in Category A.

Taxpayers, parents and children in my State have an inherent right to a high quality education. Indeed, it is the State taxpayers' money which directly pays for this educational system. Imposing the educational requirements of thousands of federally connected children on our school system without sufficient impact aid funding places an inequitable burden upon Hawaii, and threatens the State's taxpayers', parent's, and students' rights to quality education.

The administration's justification for the reduction is that the presence of Federal activities is generally beneficial to the local tax base because of increased employment and increased expenditures on property, goods and services. However, the presence of a variety of non-taxable Federal activities directly preventing the local school districts from generating sufficient revenue is ignored.

For example, military bases and federally owned low-rent housing units are exempt from local property taxes. Additionally, many who live on Federal property are not local or state tax residents and are themselves exempt from State income taxes and vehicle registration fees. Further, most military bases also provide government-subsidized "post exchanges (PXs) and family services which not only fail to generate sales taxes but at the same time take away business from the local tax-paying stores and services.

Certainly, what appears to be a spending plan which promises Federal budget savings is, in fact, the administration's failure to recognize the Federal Government's obligation to relieve some of the economic burdens imposed upon States as a result of certain Federal activities. This is precisely the situation in Hawaii. What we have here is a responsibility properly belonging to the Federal Government.

For the past 35 years, Congress has provided sufficient impact aid funding to compensate the States for the financial burden imposed upon them by the Federal Government. Now is not the time to allow the Federal Government to abrogate its basic responsibility to the people of this country. Now is not the time for the Federal Government to punish States like Hawaii and other States which have not only the obligation but have willingly taken on the obligation in connection with the children.

I would like to express my appreciation to you and your distinguished colleagues for this opportunity to present my views on impact aid. As you ponder the virtues of this program, I hope that you will conclude as I have that the program is an equitable and necessary one for our country.

Mr. Chairman, I will conclude here.

Mr. NATCHER. A fine statement. Thank you.

[The statement of Mr. Akaka follows:]

STATEMENT BY THE HONORABLE DANIEL K. AKAKA BEFORE THE APPROPRIATIONS SUBCOMMITTEE ON LABOR-HHS-EDUCATION

Tuesday, May 6, 1986

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to appear before you today. In representing the interest of both Hawaii and the people of this nation, I want to express my concerns on two subjects being considered by the Subcommittee--Impact Aid and the Medical Officer Training Program for Micronesia and American Samoa. It is hoped that the information provided will assist the Subcommittee in its deliberation of the Labor, Health and Human Services, and Education Appropriations Bill for the 1987 Fiscal Year.

IMPACT AID

As a former teacher and administrator in Hawaii's public school system and as a member of the House Appropriations Committee, I certainly appreciate the Subcommittee's efforts to respond to the educational needs of my State. In particular, I appreciate the attention that this Subcommittee has given to the Impact Aid program and to Hawaii's unique situation as the only state with a single statewide school district. The Administration's efforts to make severe reductions in Impact Aid funding will place a tremendous burden upon public school systems which rely upon the compensatory relief provided by Impact Aid.

The State of Hawaii received $9.1 million in Impact Aid for both FY85 and FY86 pre-sequestration. This amount was not spent on supplementary programs; rather, Impact Aid funding was used to cover the cost of providing regular instruction to federally-connected students. Impact Aid compensated the State for the burden imposed upon its public school system to education Hawaii's share of approximately 39,000 federally-connected students. These federally-connected students constitute nearly 24 percent of the total public school enrollment in Hawaii. I have been advised that the Administration's proposals for FY87 would reduce this amount to $8.5 million, a cut which comes at a time when many schools within the system are having a difficult time meeting the educational needs of their students. In effect, this cutback will force Hawaii to absorb a substantial tax revenue loss and service burden associated with federal activities in the State.

In comparison with the astronomical figures we deal with in our Appropriations Committee, a loss of nearly $600,000 seems nominal at best. But the effect on my State is real--a loss of 22 full-time teachers directly attributed to the elimination of Category B payments, and a loss in funding for 16 teachers from Impact Aid in Category A.

Taxpayers, parents and children in my State have an inherent right to a high quality education. Indeed, it is the State taxpayers' money which directly pays for this educational system. Imposing the educational requirements of thousands of federally-connected children on our school system without sufficient Impact Aid funding places an inequitable burden upon Hawaii, and threatens the State's taxpayers, parents, and students rights to quality education.

The Administration's justification for the reduction is that the presence of federal activities is generally beneficial to the local tax base because of increased employment and increased expenditures on property, goods and services. However, the presence of a variety of non-taxable federal activities directly preventing the local schools districts from generating sufficient revenue is ignored. For example, military bases and federally-owned low rent housing units are exempt from local property taxes. Additionally, many who live on federal property are not local or state tax residents and are themselves exempt from state income taxes and vehicle registration fees. Further, most military bases also provide government subsidized "Post Exchanges" (PXs) and family services which not only fail to generate sales taxes but at the same time take away business from the local tax-paying stores and services.

Certainly, what appears to be a spending plan which promises federal budget savings is, in fact, the Administration's failure to recognize the federal government's obligation to relieve some of the economic burdens imposed upon States as a result of certain federal activities. This is precisely the situation in Hawaii. What we have here is a responsibility properly belonging to the federal government.

For the past 35 years, Congress has provided sufficient Impact Aid funding to compensate the States for the financial burden imposed upon them by the federal government. Now is not the time to allow the federal government to abrogate its basic responsibility to the people of this country. Now is not the time for the federal government to punish states like Hawaii which have not only the obligation, but have willingly taken on the responsibility of educating federally-connected children.

In conclusion, Mr. Chairman, I would like to again express my appreciation to you and your distinguished colleagues for this opportunity to present my views on Impact Aid. As you ponder the virtues of this program, I hope that you will conclude as I have that the program is an equitable and necessary one for our country.

THE MEDICAL OFFICER TRAINING PROGRAM FOR MICRONESIA AND AMERICAN SAMOA

For the past 27 years, medical care in Micronesia has been provided primarily by a group of about 35 Medical Officers (MOs) trained at the Fiji School of Medicine. In 1980, concerns about the depletion of this cadre of MOs were raised by the MOs themselves to the University of Hawaii faculty members. They expressed their anxiety over the issue of depletion due to retirement and the fact that political changes in Fiji and changes in the academic program at the Fiji School of Medicine have greatly reduced the number of Micronesians accepted to that school.

Through the committment of this Subcommittee and its dedicated Chairman, an FY85 appropriation of $2.5 million was granted to establish a nine-year program to train 70-75 indigenous Micronesians and American

Samoans as MOs. These Officers will then be qualified to deliver primary health care services to the region and to provide public health care leadership in the Pacific.

The University of Hawaii, which is administering the program, did not receive the $2.5 million appropriation until January 1986 because of a delay on the part of the Office of Management and Budget. However, a $120,000 planning grant awarded by the Department of Interior allowed much preliminary work to be completed, including the establishment of an Advisory Committee made up of University of Hawaii School of Medicine faculty and leaders in health care from Micronesia and American Samoa, and the determination of the Pohnpei State Hospital in Micronesia as the major teaching site.

The Advisory Committee will meet in June 1986 to begin the student admissions process. As is evident from the written statement submitted to the Subcommittee by Dr. Terence Rogers, Dean of the University of Hawaii School of Medicine, extensive attention has already been given to facility renovation, the curriculum pertaining to clinical training and the teaching of the fundamental sciences, and most crucially, the method of approach. The teaching method takes into account subtle but important cultural factors such as the rigid hierarchical nature of Micronesian society. Also, the new MOs will be trained to promote prevention, having been taught about village and home sanitation and community development. The Advisory Committee anticipates the training of the first class of 20 to begin in September 1986.

Mr. Chairman, on behalf of the University of Hawaii, I thank you for your past support of this extremely important program. In the past, medical care in Micronesia has been adequate at best. Many of the medical problems have resulted from impure water supplies, inadequate sewage disposal, and overcrowded living conditions. In addition, there simply has not been enough manpower in the health care field to provide a satisfactory level of service. The training of MOs under this innovative system will do so much to ameliorate the adverse health conditions of these people. I am proud of the University of Hawaii's stewardship in striving to improve the quality of life for the people of Micronesia and American Samoa.

Thank you again for this opportunity to voice my support for these two very worthy programs.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. CHARLES WHITLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. NATCHER. Mr. Whitley, we will be pleased to hear from you at this time.

Mr. WHITLEY. I want to express my appreciation to you and the gentleman from Massachusetts for again providing us this opportunity to testify, as I have done many times over the past years, and I know from that experience that we are preaching to the choir here, because you and the gentleman from Massachusetts agree with us about the need for, and justification of, impact aid funds, both Category A and Category B.

I would ask that my statement be accepted for the record in its entirety.

The points I stressed in past years are still applicable today. Impact aid is a reasonable way to meet an obligation of our government. It is just as pressing as when the program started 35 years ago, and it has no crippling layers of bureaucracy, therefore very little delivery cost, and it goes directly to the need by going directly to a school district. It largely free of public criticism and scandal, and it is flexible.

Mr. NATCHER. Thank you, Mr. Whitley, you have made an excellent statement.

[The statement of Mr. Whitley follows:]

CONGRESSMAN CHARLIE WHITLEY

TESTIMONY ON CONTINUATION AND FUNDING OF PL 81-874

SUBCOMMITTEE ON LABOR - HEALTH
AND HUMAN SERVICES - EDUCATION

MAY 6, 1984

Mr. Chairman, three school systems in my district - the North Carolina third - are classic examples of inequitable tax situations caused by the impact of federal installations, situations that Public Law 874 was designed to correct.

The Onslow County school system, impacted by the Camp Lejeune - New River Marine Corps Air Station complex, has 6,284 "B" category students who constitute 39 percent of the student population. The system's receipts from PL 874 for the 1985 fiscal year will be about $800,687.

The Wayne County and Goldsboro City school systems are impacted by the presence in Goldsboro of Seymour Johnson Air Force Base. There are, in the Wayne County system, 2,021 federally-connected students who make up about 16 percent of the student population. The Wayne County PL 874 entitlement was $636,096 for fiscal year 1985. The Goldsboro system had 1,443 federally-connected "super B" students last year and that system's entitlement was $205,239.

As you know, Mr. chairman, these entitlements represent greatly reduced federal support in the context of the original scope and intent of Public Law 874. Nevertheless the superintendents tell me that further cutbacks or elimination of the funding will cause cutbacks in personnel and programs.

Despite the erosion of entitlements and receipts as originally established under Public Law 874, I know of no federal program in my district with a better track record in terms of cost-effective use, freedom from scandal, effective control by local government and flexible utility.

As I have often reminded this committee, the obligation to compensate local school districts for the non-taxable nature of federal installations is acknowledged, widely recognized and accepted. Many responsible studies recommend funding at levels even higher than those permitted by current law.

Mr. Chairman, the three heavily impacted school systems in my district have been fulfilling their obligations for a number of years to educate the children of military and other federally-supported families. They have not held back. Local tax support has been excellent. The military children from our schools have shown themselves capable of performing well in schools around the world. Educators in Wayne County, Goldsboro and Onslow County are determined to make certain that second class education for their children never becomes one of the sacrifices we ask of those who defend our country.

Changes or cutbacks in the "super B" designation would cause very severe financial hardship for the Goldsboro and Onslow County districts. Further cutbacks in in "B" category funding will deepen tax payment inequities that already exist in Wayne County.

Mr. Chairman, I do not believe anyone in my district would seriously question the value of the so called "B" designated families to our community. Most of them pay property taxes, spend much of their income in tax-generating stores and contribute to the local economy in other ways too numerous to list. It is true, however, that each also adds to the inequity of the tax burden for supporting the schools, and the need for and fairess of compensation through Public Law 874 is just as relevant today as it was in 1950 when Impact Aid was introduced.

Mr. chairman, I will conclude with a summary of points I have stressed before this subcommittee today and in years past:

- Impact aid has been a just and reasonable way to meet a legitimate obligation of the U.S. government. The need and the obligation are just as pressing, just as binding today as they were 36 years ago.

- The program has no crippling layers of bureaucracy; it has very low delivery cost compared with other aid-to-education programs; and it goes directly to the need by going directly to the school district.

-It is largely free of public criticism and untainted by scandal.

- It is flexible.

Mr. Chairman, I respectfully request that the subcommitte support the continuation of funding under Public Law 874 for the school systems in my district and other qualifying districts throughout the nation. I ask the subcommittee's support for the positions of the National Association of Federally Impacted Schools as outlined and explained in its various publications.

Mr. Chairman, I thank you and the other members of this subcommittee for this opportunity to speak on behalf of Impact Aid to public schools under Public Law 874.

Tuesday, May 6, 1986.

IMPACT AID

WITNESS

HON. NORMAN D. DICKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. **Natcher**. We will now hear from the next three witnesses, Mr. Morrison, Mr. Swift, and Mr. Dicks.

Mr. **Dicks**. Well, Mr. Chairman, I will put my statement in the record and I wish to say we appreciate the opportunity to be here today. The State of Washington is very dependent on Impact Aid and we need Category A and B funding. I used to work for a Senator that chaired this committee, on the other side. He is not in the Senate anymore but the real responsibility for protecting health funding, education, vocational education, dislocated workers, student aid really rests with this committee. The Chairman and Mr. Conte over the last five years, have done an outstanding job of protecting important programs like Impact Aid and I just want to say that we appreciate your efforts and you will have our support on the full committee and on the floor. It is truly the people's bill.

Mr. **Natcher**. Thank you.

[The statement of Mr. Dicks follows:]

STATEMENT OF CONGRESSMAN NORMAN D. DICKS, M.C.
HOUSE APPROPRIATIONS SUBCOMMITTEE ON
LABOR-HEALTH AND HUMAN SERVICES-EDUCATION

MAY 6, 1986

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR ONCE AGAIN GIVING ME THE OPPORTUNITY TO TESTIFY BEFORE THE SUBCOMMITTEE ON THE IMPORTANCE OF THE FEDERAL IMPACT AID PROGRAM.

A MAJORITY OF THE SCHOOL DISTRICTS THROUGHOUT THE COUNTRY DEPEND ON THE REVENUES GENERATED FROM LOCAL PROPERTY TAXES TO SUPPORT PUBLIC SCHOOLS. IN MANY AREAS HOWEVER, THIS REVENUE IS LOST BECAUSE A SIGNIFICANT PORTION OF THE PROPERTY IS FEDERALLY-OWNED AND THEREFORE NOT TAXABLE. SCHOOL DISTRICTS IN THESE AREAS ARE EXPECTED TO EDUCATE MILITARY DEPENDENTS AND THE CHILDREN FROM OUR INDIAN RESERVATIONS BUT DO NOT REAP THE BENEFITS OF INCREASED REVENUES.

FOLLOWING THE SECOND WORLD WAR, CONGRESS RECOGNIZED THAT AN UNFAIR FINANCIAL BURDEN WAS BEING PLACED ON LOCAL SCHOOL DISTRICTS AND AGREED TO REIMBURSE THESE DISTRICTS FOR LOST REVENUE. THROUGH THE PASSAGE OF P.L. 81-874 WE COMMITTED

OURSELVES TO INSURING A STANDARD LEVEL OF EDUCATION FOR ALL FEDERALLY CONNECTED CHILDREN.

THE PRESIDENT'S FISCAL YEAR 1987 BUDGET ONCE AGAIN ASKS CONGRESS TO RENEGE ON ITS COMMITMENT TO QUALITY EDUCATION FOR FEDERALLY-CONNECTED CHILDREN BY ELIMINATING PAYMENTS FOR CATEGORY "B" STUDENTS, THOSE CHILDREN WHOSE PARENTS EITHER LIVE OR WORK ON FEDERAL PROPERTY. NEARLY ONE-THIRD OF THE SCHOOL DISTRICTS IN WASHINGTON STATE DEPEND ON IMPACT AID FUNDS. THE ELIMINATION OF THE CATEGORY "B" FUNDING WOULD RESULT IN A $4 MILLION LOSS TO THE STATE, AFFECTING 49,000 STUDENTS SERVED BY THE PROGRAM.

AS A MEMBER OF CONGRESS I AM COMMITTED TO REDUCING THE FEDERAL DEFICIT IN THE MOST FAIR AND EQUITABLE FASHION. HOWEVER, I DO NOT BELIEVE THE ADMINISTRATION'S PROPOSAL DISMANTLE THE IMPACT AID PROGRAM IS THE ANSWER. WITHOUT THIS FEDERAL ASSISTANCE THE QUALITY OF EDUCATION FOR A CONSIDERABLE NUMBER OF YOUNG PEOPLE WILL DETERIORATE, AND COMMUNITIES WHICH HAVE ACCEPTED THE FEDERAL GOVERNMENT'S PLACEMENT OF FEDERAL MILITARY INSTALLATIONS WITHIN THEIR BOUNDARIES WOULD BE UNFAIRLY PENALIZED.

LET ME GIVE YOU AN EXAMPLE. THE SIXTH CONGRESSIONAL DISTRICT IN WASHINGTON STATE INCLUDES THREE MAJOR MILITARY installations: McChord Air Force Base, Ft. Lewis Army Post, and the Puget Sound Naval Shipyard.

The Clover Park School District serves both McChord Air Force Base and Ft. Lewis. Clover Park is one of the largestschool districts in Washington with over 12,000 students in grades K through 12. Currently the district maintains eighteen elementary schools, four junior high schools, two senior high schools and an alternative school. The district also operates one of the state's five vocational-technical institutes, an elective high school and three educational programs at Western State Hospital.

Out of the total K through 12 enrollment of over 12,000 students, 7,000 students have parents connected with military installations. Approximately 4,600 of these students live on base and are considered category "A" children, while the remaining 2,500 category "B" students live in the nearby community of Lakewood.

The elimination of category "B" students from the Impact Aid program would mean a $400,000 reduction in revenues for the Clover Park School District. As the military population in this area continues to grow so will the student population. It is unfair to expect that this school district can provide quality

EDUCATION FOR AN INCREASING DEPENDENT POPULATION WITH REDUCED REVENUES.

In the Central Kitsap School District there are three major federal facilities: the Naval Undersea Warfare Experimental Station, the Bangor Naval Submarine Base, and the Puget Sound Naval Shipyard. The latter is also part of the Sixth Congressional District.

Total enrollment for the Central Kitsap School District is 9,000 students. Approximately 70% of these students are eligible for Impact Aid funds, and close to 5,000 of these children qualify as category "B" students. Category "B" funding is an essential component of the Central Kitsap School District budget. Contrary to the President's assumptions if this money were to be eliminated it could not be made-up by the school district. A Washington State statute referred to as the "Levy Lid Law" prohibits school districts from raising money at the local level.

The financial needs of the Clover Park and Central Kitsap School Districts are not unique. School districts across the country serve large populations of students whose parents are employed by the federal government, and these school districts depend on Impact Aid funding to maintain their curriculums.

THE FEDERAL GOVERNMENT MADE THE COMMITMENT TO REIMBURSE LOCAL SCHOOL DISTRICTS FOR LOST REVENUES THROUGH THE IMPACT AID PROGRAM. I DO NOT BELIEVE THAT WE CAN NOW TURN OUR BACK ON THIS PROMISE AND EXPECT THESE SCHOOL DISTRICTS TO CONTINUE TO PROVIDE QUALITY EDUCATION FOR OUT CHILDREN.

I RESPECTFULLY REQUEST THAT THE SUBCOMMITTEE NOT ACCEPT THE PRESIDENT'S PROPOSAL TO ELIMINATE THE CATEGORY "B" FUNDING FOR FEDERAL IMPACT AID.

THANK YOU.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. SID MORRISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. NATCHER. Mr. Morrison, go right ahead.

Mr. MORRISON. We are truly involved with this program, Mr. Chairman. The State collects about $23,000,000, of which $5,000,000 comes into my central part of the State. Again, my support will be there to back up the work of this subcommittee. I would like to select one school district just to describe the problem which I find not too dissimilar from other testimony.

The Wapato School District, 80 percent of the land on the Yakima Indian Reservation, and 75 percent of the 2,500 students in this district are of minority extraction. 75 percent qualify for the special lunch program, this is not a wealthy district at all. The remaining 20 percent of the district being eligible to pay taxes, in our State. We have a divided system with approximately a quarter of the total cost coming from local taxpayers and that 20 percent is eligible to pay 100 percent of the costs, so this is a vitally important program for us. And I will be happy to support the work of the subcommittee

Mr. NATCHER. Thank you, sir.

[The statement of Mr. Morrison follows:]

TESTIMONY OF CONGRESSMAN SID MORRISON
BEFORE THE HOUSE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION
May 6, 1986

Thank you, Mr. Chairman, for this opportunity to submit my views on the importance of the Impact Aid program, both parts A & B, in the education of our young people. Because the Congressional District I represent contains 75 different school districts, I would like to tell you about just one of them that I believe illustrates the crucial nature of the P.L. 81-874 program to many of us.

Before I do, Mr. Chairman, let me first commend you on your inclusion of disaster assistance for the Impact Aid maintenance and operations program in the Urgent Supplemental Appropriations bill. This recognition of critical need by your subcommittee shows sensitivity to these unique and pressing circumstances faced by a number of schools. At the same time, this special appropriation serves to underscore the crucial nature of this funding program to the everyday functioning of many of our nation's schools.

I'd like to tell you about the Wapato School District, which is located in the heart of the Yakima Valley, in the central part of Washington State. Because almost eighty percent of the school district is within the Yakima Indian Nation Reservation, and the Valley's main industry is agriculture, roughly 70 percent are from minority backgrounds. And of the over 2500 students enrolled in the Wapato School District, 75 percent qualify for some aspect of the special lunch program. It is not a wealthy school district.

While the State of Washington picks up roughly 77 percent of the cost of educating its students, the additional 23 percent must come from special levies or federal funding. Because eighty percent of the property in Wapato School District is non-taxable, residents living on taxable land would have to be taxed at twice the state average to pick up the tab. In other words, the persons owning twenty percent of the land would bear 100% of the tax burden. That's just not fair. As you know, Mr. Chairman, that was why the Federal Government established the Impact Aid program in the first place.

P.L. 81-874 funds are intended to assist with the costs of educating children from families which are, in one way or another, "federally connected". Impact Aid is simply reimbursement for services rendered. To Wapato, it means salaries for the services of the 21 teachers that must be hired to teach these 657 Impact Aid youngsters.

Another way to see how the presence of these youngsters is felt is to consider that to place a new math book in the hands of each of these 657 students will cost roughly $14,000. Excellence in Education is an admirable goal, but it has a price tag, too.

Now, not all the school districts in Central Washington share this particular blend of students, but virtually all of these schools qualify and rely on P.L. 81-874 payments for one reason or another. Whether the students have parents who work at the Hanford Nuclear Reservation in Richland, Washington, or the U.S. Army's Yakima Firing Center in Yakima County, their schools must provide resources for them. Washington State is entitled to almost $23 million, and the school districts in my part of the State qualify for almost $5 million.

And that, Mr. Chairman, is why I am pleased to have been given the opportunity to share my support for maintaining both the A and B components of the Impact Aid program.

Mr. Chairman, in closing, I wish to thank you for the careful attention your subcommittee has given the Impact Aid program in the past. I appreciate this opportunity to submit my views to the subcommittee on continued funding for this important program, and look forward to working with you in this effort.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. AL SWIFT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. NATCHER. Mr. Swift, we will be glad to hear from you at this time.

Mr. SWIFT. I ask unanimous consent to insert a prepared statement in the record, along with the comments of the Oak Harbor School District, Shelton Schools, Ferndale, and the Taholah Schools. Every year we meet here and you and this committee go out and provide the bulwark of our defense against those who would reduce this program and also provide the positive effort to see that this program continues. I know you need support and I will ask unanimous consent to make a part of the record a letter from our delegation to you, asking for your support on this measure, and also assuring you of our support when you bring the bill to the floor.

Mr. NATCHER. Thank you.

[The statement of Mr. Swift follows:]

TESTIMONY OF CONGRESSMAN AL SWIFT

BEFORE THE
SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION
OF THE
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

MAY 6, 1986

MR. CHAIRMAN, thank you for giving me the opportunity to testify today before you and your committee in support of a reasonable level of funding for Impact Aid and School Construction in Federally Affected Areas.

The 81st Congress saw fit to create these two programs to address the needs of school districts whose financial ability to provide educational programs and facilities is restricted by the presence of a federal installation. The rationale for these programs is as sound as it was in 1950. From that time to now, Congressional support for Impact Aid has been strong--and opposition to it by successive Administrations since then has been regular and expected. This is not necessarily a bad thing--on the contrary, we should be prepared constantly to defend our position. We have done that and, thanks to your leadership over the years, Mr. Chairman, we have been able to keep the programs in the budget.

I am submitting, along with my written testimony, a letter from other members of the Washington State delegation in support of PL 81-874 and PL 81-815 funding at least at FY 85 levels. I can't emphasize too strongly the need to maintain these two programs at a realistic level. Perhaps "realistic" is even too generous a term in describing a $20,000,000 amount for PL 81-815 funding, as there is currently about $300,000,000 worth of applications for this little-known program that provides emergency construction monies for federally impacted school districts.

Those persons responsible for educating our children have told me they understand the need to reduce the budget deficit, and they have accepted freeze levels for several years. As you and I and they know, this means they have accepted cuts. They have been able, through careful planning, creative administrative techniques, and doing without, to provide educational services to our youngsters. They can't do this indefinitely and they need to know that Congress will renew its commitment to federally impacted schools through funding at FY 85 levels of these two small, but vital programs. It's time to say, "This far and no farther."

Additional comments from school districts in the 2nd Congressional District of the State of Washington:

Oak Harbor School District--Island County
Dr. Pat Hayden, Superintendent

Oak Harbor is the site of the Whidbey Island Naval Air Station. Approximately 65% of the students are military dependents. Out of the total, 1,064 are "A" and 2,263 are "B" Category students. Impact Aid funding comprises 12.4% of our total school budget. The original reasons for 874 funding were valid; the specific justification and need for 874 funding in this district are very real and acute. It is not fair to the relatively few civilians to pay the bill for everyone.

Sedro Woolley School District--Skagit County
Dr. Pam Carnahan

Impact Aid funds have enabled us to hire an elementary counselor to address the needs of Indian children attending Sedro Woolley School District. With the cuts in Johnson-O'Malley funds, the 874 funding is especially important to our school district.

Shelton School District--Mason County
Dr. Richard Smith

With an 80% dropout rate among the Indian children we serve, special programs have been instituted to motivate and stimulate these youngsters educationally. The cutback in Johnson-O'Malley funding will severely restrict our ability to address these special needs. We sincerely hope that 874 funding will be sufficient to allow us to continue these programs.

Ferndale Public Schools
P.O. Box 698 Ferndale, Washington 98248 (206) 384-9200

April 1, 1986

The Honorable Al Swift
U.S. Congressman
1502 Longsworth House Office Bldg.
Washington, D.C. 20515

Dear Representative Swift:

I urge you to vote against the proposal to cut Impact Aid funds.

Background

The one hundred fifty square miles of Ferndale School District includes communities supported through fishing and farming, three major industries (Mobil, Intalco, and ARCO), and also contains the entire Lummi Indian reservation. A major source of revenue is property taxes. Home owners, farmers, and industry all support schools by paying these taxes. However, those living on and working on the reservation and other federal installations in the district do not. Impact Aid funds were created by the government in recognition of this fact.

For the Ferndale School District, Impact Aid is an in lieu of tax payment in exchange for services rendered. The funds are essential for the operation and maintenance of the educational program and, because of state restrictions, cannot be replaced by any other source of revenue. If Impact Aid funds were supplemental, the proposed cuts would not be so potentially devastating.

Use of Impact Aid Funds

Impact Aid funds are placed in the general fund to reduce the shortfall of revenue needed to operate many programs which are not fully funded by the state or local levy. Both the local levy (property tax) and P.L. 874 funds are used to affect the shortfall of state funding. Following is a list of Ferndale School District programs which use levy and P.L. 874 dollars to meet programs costs:

Program	Additional Resources Needed
Basic Education	<$ 1,274,620>
Remediation	<$ 139,049>
Special Education	<$ 100,000>
Indian Education	<$ 51,457>
Traffic Safety	<$ 13,175>
Gifted	<$ 44,464>
Food Service	<$ 47,669>
Transportation	<$ 289,066>
Library Resources	<$ 100,000>

Impact of Cuts

A 20 to 25% cut in 1987 would mean a serious reduction in programs for the Ferndale School District. Most programs affected will be those designed to meet the educational problems of high need children. P.L. 874 funds supplant the local levy funds which are used to support maintenance and operation of the basic program. If P.L. 874 funds are reduced, in combination with cuts in other federal programs, the district will be forced to curtail needed services in the programs listed above.

Summary and Conclusions

It is essential that programs for all students with special needs continue to be provided. The Ferndale School District is committed to the "Excellence in Education" movement and is concerned about improving the skills of all students. Indian reservations and their related needs and costs are the responsibility of the entire nation. When school districts are unable to generate revenue from non-taxable federal property, they must rely on the government to pay its fair share of the local property tax.

Sincerely,

Dennis L. Peterson
Superintendent

DLP/clm

TAHOLAH
SCHOOL DISTRICT No. 77
TELEPHONE (206) 276-4729
P. O. BOX 249
TAHOLAH, WASHINGTON 98587

May 1, 1986

The Honorable Al Swift
1502 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Swift:

We express alarm that the current administration has proposed major reductions in the FY87 education appropriations for two Federal education programs designed to compensate local school districts for an extensive Federal presence, primarily from land and families associated with military installations and the presence of American Indian Reservations and their respective Indian children. The two Federal programs, P.L. 81-874 known as "Impact Aid" and P.L. 81-815 representing "School Construction in Federally-Affected Areas," provide assistance to local schools responsible for educating these Federally-connected students. We request your assistance with Congress in restoring these logical Federal initiatives to their FY85 levels of $650 million for Impact Aid and $20 million for school construction.

The Federal presence of American Indian Tribes and their reservation lands within your Congressional District is a prime example of the need to maintain these Federal appropriations. At least fifteen Federally-recognized Indian Tribes with a population estimate of 9000 American Indian people live within the District. The Indian children as well as those children whose parents live or work on military installations receive public instruction. Local school levies and bonds, the normal revenue sources for school districts for provision of instruction and buildings, simply can't be applied to the federal lands and their associated families. The 874 and 815 appropriations are designed to ensure that other residents of the local school districts are not disproportionately burdened financially for the Federal presence.

From a national perspective, the proposed cuts in the P.L. 81-815 reveals a most illogical policy. The FY85 Appropriations of $20,000,000 provided $8,500,000 for school construction on military installations; $8,500,000 for school

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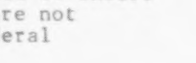

constructions on Indian lands: and, $3,000,000 for school construction on Federally-impacted non-taxable land. Although the administration requested zero funding for FY86, Congress restored 815 funding to $20 million in the FY86 continuing resolution. Prior to passage, a Congressional-Administration compromise reduced funding to $17.5 million. And, the Gramm-Rudman sequestration reduced the level further to $16.7 million.

The administration request for FY87 to address P.L. 81-815 needs is $5 million with the reduction justification that the Defense Department was addressing school construction demands. There was no mention of the ever-increasing backlog of applications to address Indian-impacted construction needs.

There are 119 military applications for school construction pending estimated at $90,269,000. Applications pending for school construction on Indian lands total 94 estimated at $208,070,000. The responsibility rests with the Federal government for construction costs as the local tax base is seriously inadequate to provide compensation for these Federal activities due to the predominance of Federal or Trust land.

For example, the Taholah School District, located within the boundaries of the Quinault Indian Reservation on the Pacific Coast within your District, provides educational instruction for 170 full-time students from kindergarten through the eighth grade. Currently, Taholah School District students attend high school in the North Beach School District High School located ten miles south of Taholah. The North Beach School District plans to move its school facilities 20 miles further south to Ocean Shores, Washington.

The Quinault Indian people residing in the Taholah School District voted in public referendum in February, 1984 to establish a high school program for their students. The high school program, endorsed by surrounding school districts, will provide a continuity of quality educational instruction for the youth residing in Taholah and local communities. The Washington State Board of Education has authorized a high school at Taholah. As the district resident population is predominantly Quinault Tribal members, Federal assistance for construction will be necessary to provide school facilities for an estimated 100 high school students as normal local and State sources for construction revenue are seriously inadequate to the District due to the predominance of Federal Trust lands. And, the North Beach School District is not planning to house Taholah District students when the new high school is occupied.

Congressman Swift
May 1, 1986
Page 3

The administration proposal to dramatically reduce the 815 program is most ill-advised as Federal resources are fully recognized by legislative intent to be the only revenues available in these unique situations to adequately address necessary construction financing. We urge your strong support to restore P.L. 81-874 and P.L. 81-815 to their FY85 levels.

Sincerely

Darrell Olson

Darrell Olson
Superintendent

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2d District, Washington

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COMMITTEE ON
ENERGY AND COMMERCE

Subcommittee on Telecommunications,
Consumer Protection, and Finance

Subcommittee on Energy Conservation
and Power

Chairman,
Special Subcommittee on
U.S.-Pacific Rim Trade

COMMITTEE ON
HOUSE ADMINISTRATION

Chairman,
Subcommittee on Elections

May 6, 1986

The Hon. William H. Natcher
Chairman
Labor-Health and Human Services-Education Subcommittee
House Appropriations Committee
2358 Rayburn HOB
Washington, DC 20510

Dear Chairman Natcher:

We, the following Members of the Washington State Delegation, wish to express our support for the PL 81-815 "School Construction in Federally Affected Areas," and PL 81-874 "Impact Aid" programs which have long been recognized by Congress as appropriate Federal assistance to those school districts which experience a disproportionate financial burden created by civilian and military installations and American Indian reservations.

We request that the subcommittee give full consideration to providing appropriations at the FY 85 level for school construction and Impact Aid. The PL 81-815 program now has over $300 million in school construction applications pending to address military and Indian district needs, and the PL 81-874 Impact Aid program represents far less than full entitlement at the current $646 million level.

The philosophy of transferring educational responsibilities to State and local governments has merit in selected areas. The PL 81-815 and PL 81-874 programs, however, deserve Federal assistance with a continuity of appropriation levels.

We appreciate your serious consideration of these issues.

Sincerely,

Tom Foley
TOM FOLEY, MC

AL SWIFT, MC

Norm Dicks
NORM D. DICKS, MC

Don Bonker
DON BONKER, MC

Mike Lowry
MIKE LOWRY, MC

Sid Morrison
SID MORRISON, MC

John Miller
JOHN MILLER, MC

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. NATCHER. Mr. Panetta.

Mr. PANETTA. I ask that my statement be made part of the record. I am here to sing hallelujah, amen, and ask you to keep the faith, and I appreciate your support on this program.

Mr. NATCHER. Thank you, Mr. Panetta.

[The statement of Mr. Panetta follows:]

TESTIMONY BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

MAY 6, 1986

LEON E. PANETTA
16th District, California

I would like to begin by expressing my appreciation to the Chairman and the entire Subcommittee for allowing me to testify today on the fiscal year 1987 appropriations for the P.L. 81-874 Impact Aid program. I have had the pleasure of appearing before you in past years on this same subject, and the Subcommittee has always been very supportive. It is my hope that the commitment to this important program will be maintained in the future.

Mr. Chairman, as you know, Impact Aid has been an essential portion of the federal education budget each year since its inception in 1950. Through the passage of P.L. 81-874, Congress recognized the indisputable responsibility of the federal government to reimburse local school districts whose education budgets are severely constrained due to federal activities in their area. Today, the original rationale for the program is no less compelling than it was 36 years ago. In school districts which contain federal installations such as military bases, government facilities, and Indian reservations, federal land ownership decreases the amount of local tax revenues available to support the public education system. At the same time, these federal activities increase the number of children that the local education institutions must serve. Clearly, the federal government has an obligation to compensate these doubly burdened school districts.

Unfortunately, the present Administration has not been predisposed to meet this obligation. In every budget proposal submitted to Congress since he took office, President Reagan has attempted to cut funding for this essential program. Since 1981, the Impact Aid appropriation has fallen far below both the levels intended in the original legislation and the actual cost of educating federally connected children. Beginning in FY 1982, Impact Aid payments declined by 38 percent from the FY 1981 level, largely as a result of the enactment of the Omnibus Budget Reconciliation Act of 1981. For FY 1983, the President requested an additional 34 percent cut, for a total two year reduction of $348 million. Fortunately, Congress rejected this short-sighted proposal, and provided a substantial increase in Impact Aid funding including a $60 million appropriation for construction.

In fiscal years 1984, 1985 and 1986, Congress again rejected the President's proposed reductions and continued on the path of restoring funding for the Impact Aid program. In 1984, Congress reaffirmed its support by reauthorizing Impact Aid for three years, maintaining payments for Section 3(b) students which President Reagan has continuously targetted for elimination.

Now, however, federally impacted school districts must cope with the spector of Gramm-Rudman which has already sliced 4.3% from their FY 1986 payments. Whereas in FY 1985, school districts received up to $1,430 per pupil compensation, this year they will receive no more than $1,368. Preliminary estimates of additional cutbacks that would be imposed should Congress and the President fail to pass a budget which meets the deficit targets specified under Gramm-Rudman indicate that the maximum per-pupil payment could fall to as low as $916 by FY

1988.

Clearly such an outcome is neither intended nor desired by this Congress. Impact Aid is an entitlement program. The grants allocated to local school districts are payments for services rendered, not some unnecessary luxury that can be easily cut back in times of fiscal restraint. Each dollar cut from the Impact Aid budget represents an additional dollar that local school districts will have to find from already constrained budgets to pay for services requisitioned by the federal government. We have no more right to expect the nearly 4,000 school districts receiving Impact Aid to subsidize the federal government in this manner than individual workers can expect the government to excuse them from their tax obligations if they decide that they would rather not pay up in a given year. Just as the health care costs of the military personnel's children are borne by the federal government and not by local taxpayers, so it is with the educational burden placed on federally-impacted school districts.

To its credit, the Subcommittee has taken an important leadership role in preventing the further truncation of the Impact Aid program. On behalf of a number of federally-impacted school districts in my Congressional District, I would like to thank you for your continued far-sighted approach.

However, it is important to point out the constraints under which these school districts are operating. The Monterey Peninsula Unified School District, a heavily impacted district in my area, has been especially hard hit in recent years, absorbing both the cutback in federal funds and reductions in state school contributions brought about by Proposition 13.

Now the President is once again proposing to eliminate funding for Section 3(b) children whose parents either live or work on federal property. The Administration claims that these children "do not represent an actual burden to the school districts that educate them." Clearly this is not the case. Taking the Monterey Peninsula Unified School District as an example, one can easily identify a number of very significant ways in which the presence of federally connected installations increase the burden on local school districts and their permanent residents, even if the personnel do not live on federal property. A full 57% of the Monterey district's land is federally-owned and is therefore not subject to taxation. At the same time, more than 53 percent of the district's students are military-related. While most school districts can rely on the revenue generated by both the residential and commercial property, this funding support does not exist for Monterey's B students. When the parents work on land that is exempt from property taxes, a very significant portion of the revenue base is eliminated. Without federal compensation, the burden on local residents can be doubled.

Moreover, even the military personnel who live off base do not pay taxes like other families in the community. The Soldiers and Sailors Relief Act allows them to maintain their legal residences in other states so that property taxes on automobiles and other personal property and state income taxes are paid to their home states and not where their children attend school. In addition, military families can use the PX and commissaries which are exempt from state sales tax.

Clearly, the presence of these families present a financial burden for local school districts which are not insignficant, as the Adminstration contends.

In conclusion, let me reiterate that Impact Aid is a responsibility and an obligation of the federal government which should not be subject to compromise. We must live up to the commitment we have made to our military personnel to provide their children with a quality public education. We depend on local school districts to help us fulfill that commitment. They have lived up to their end of the bargain by welcoming federal employees and their children into their communities with open arms. We cannot now turn our backs on these districts. The federal government must be willing to shoulder its fair share of the burden. This Subcommittee has repeatedly demonstrated its willingness to meet that challenge. I hope and expect that it will continue to do so in FY 1987. Thank you.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. GLENN ENGLISH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. NATCHER. Mr. English, we will be glad to hear from you.

Mr. ENGLISH. Thank you very much, Mr. Chairman.

I think that we all recognize and understand that the need for these tax funds have not lessened any at all. Certainly the responsibility for educating the children of the various school districts that are involved but who do not contribute to the local tax base, continues as it has in the past. Over the years we have seen the level of Federal funds for impact aid diminished, but certainly the need for those funds has not diminished in anyway. Now we see that the President is proposing the elimination of Category B funding. We certainly recognize the impact this would have on many States throughout this Nation, and particularly in my own home State of Oklahoma.

During these times of very difficult economic stress in the State of Oklahoma, in the area of agriculture and certainly in the area of energy, we are in the throes of what we would have to describe as a depression, and State government and certainly our school systems in that State are suffering mightily. If these funds were denied to those school districts, it would be catastrophic. I would plead with you, Mr. Chairman, that this is very difficult time for our State, and I would dare say with other agriculture and energy-producing States, to see these funds withdrawn.

So, Mr. Chairman, I would simply urge the committee to once again insist that impact aid be continued and also, Mr. Chairman, I would like to join in commending this subcommittee and its Members for insisting over the years that this worthy project be carried out.

Mr. NATCHER. Thank you.

[The statement of Mr. English follows:]

TESTIMONY OF CONGRESSMAN GLENN ENGLISH

BEFORE

THE HOUSE EDUCATION SUBCOMMITTEE

ON

LABOR-HEALTH AND HUMAN SERVICES-EDUCATION

MAY 6, 1986

Chairman Natcher, members of the subcommittee, thank you for allowing me this opportunity to appear before you today in support of the Impact Aid program.

The arguments in support of Impact Aid remain the same and I won't dwell on them this afternoon. It is sufficient to say that many public school districts throughout the nation are charged with the responsibility of educating children whose parents do not contribute to the local tax base. These are youngsters from military bases, Indian lands and certain other special categories. Presidential Commissions have studied and validated the federal obligation to those public school districts educating federal children. Yet, over the years, funding levels for Impact Aid have diminished and recent appropriations have been far below the levels needed to fully fund the program. Now, once again, the President has proposed elimination of category "B" funding.

In Oklahoma, over one-half the state's public school districts receive impact aid--this equates to 52,000 plus students. Many of these children are category "B" and qualify under the indian lands provision of P.L. 81-874. Elimination of category "B" will mean that many schools in Oklahoma would lose all impact aid because they would not have enough students to qualify without both "A" and "B" students. This will create a serious financial burden for many Oklahoma school districts at a time when their financial resources are already stretched to the limit.

Mr. Chairman, as you may have noticed from news reports, the economy of Oklahoma isn't doing well. My state, which depends on agriculture and the petroleum industry for its operating revenue, is in the throes of a depression. All areas of state government, including the public schools, are affected. Schools are having to scramble for every penny. In some instances teachers are being laid off and administrators are having to look very hard at every program offered by their school districts.

Elimination of impact aid monies will be a serious blow to Oklahoma schools that are already reeling under the budget axe. School administrators tell me that impact aid funding is so important to them because it can be used where it best meets the needs of the school district. In these difficult times for Oklahoma schools, this funding is now more important than ever.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. RON PACKARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **NATCHER.** Our next witness is our friend and colleague from California, Mr. Packard. We will be pleased to hear from you.

Mr. **PACKARD.** Thank you, Mr. Chairman and Members of the committee. I appreciate the opportunity to appear before you. Impact aid to my district is critical. I have a written testimony, but it is a little lengthier than I would like to give, and I will simply give you some background of where my interest comes from. I served on a local school board in my district for 12 years. It is not the most critical school district in my present Congressional district, as it relates to impact aid, however there are many districts surrounding Camp Pendleton (the largest Marine Corps base in the country) that are impacted by that huge base.

Impact aid has been a significant part of their budgets. They are unanimously in favor of us perpetuating that source of revenue, recognizing their responsibility to educate the children of those military people. We also have some Indian reservations in our district where impact aid applies. Our school districts are doing a good job of instructing these students, but they are very, very much in short supply of funds.

To cut off the funds of the 874 monies would be almost catastrophic in some school districts' budgeting processes. I am here to urge the committee to seriously consider full funding of the A category students and districts, and also as much of the B category as the budget can permit (recognizing the constraints of Gramm-Rudman and other serious budget constraints).

I certainly would like to suggest that even though this hearing does not apply to your 815 monies, this too is of critical importance. I simply want to let you know in advance of the hearings you will be holding that these funds are extremely important for the building of school facilities in these districts surrounding Camp Pendleton.

I cannot overemphasize how important it is to the budgeting process.

Good education is taking place, but it is due to (in large measure) adequate funds coming through the impact aid process. So, I would urge you, Mr. Chairman, along with the Members of your committee, to give serious consideration to funding at the levels that we have had in the past year—of both the A and the B categories.

I certainly recognize that you have some difficult decisions to make in terms of the budget. I am involved in that process with you, but there are some areas where I think that we cannot shortchange our process. The education of those families who are involved in our national defense program or our Native Americans ought not to be shortchanged.

It is important that these districts receive the funds that are not coming from the displacement of local revenues through the military and through nontaxable properties. So, Mr. Chairman, I appreciate the chance to address this issue. I have been a strong supporter of Impact Aid since I have come to Congress, and will continue to support the movement this committee forward in that direction.

Mr. NATCHER. Thank you, Mr. Packard, you have given us an excellent statement, and we appreciate your appearance before the committee.

[The statement of Mr. Packard follows:]

TESTIMONY OF
CONGRESSMAN RON PACKARD
REGARDING IMPACT AID
BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR— HEALTH AND HUMAN SERVICES—EDUCATION
TUESDAY, MAY 6, 1986

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MR. CHAIRMAN, I APPRECIATE THIS OPPORTUNITY TO APPEAR BEFORE YOUR SUBCOMMITTEE IN SUPPORT OF IMPACT AID.

THE FEDERAL GOVERNMENT HAS PROVIDED ASSISTANCE TO LOCAL SCHOOL DISTRICTS THROUGH IMPACT AID SINCE 1950. THE PROGRAM WAS DESIGNED TO REPLACE TEMPORARY FEDERAL PAYMENTS INTENDED TO ENABLE LOCAL SCHOOL DISTRICTS TO PROVIDE EDUCATIONAL OPPORTUNITIES FOR CHILDREN WHO LIVED WITHIN THE SCHOOL DISTRICT, AND WHOSE PARENTS LIVED OR WORKED ON FEDERAL PROPERTY. THE FEDERAL IMPACT AID PROGRAM PROVIDES REVENUES AND COMPENSATES SCHOOL DISTRICTS FOR PROPERTY LOSSES RESULTING FROM THE PRESENCE OF TAX-EXEMPT FEDERAL PROPERTY WITHIN THE DISTRICT AS WELL.

IMPACT AID FUNDS ARE ALLOCATED THROUGH SEVERAL FORMULAS THAT REFLECT DIFFERENT CATEGORIES OF CHILDREN, AND ALSO THE LOCAL TAX EFFORT AS MEASURED BY PROPERTY REVENUES PER UNIT OF ADA. THE DIFFERING FUNDING FORMULAS RECOGNIZE TWO BASIC CATEGORIES OF STUDENTS: "A" STUDENTS LIVE ON FEDERAL PROPERTY IN THE SCHOOL DISTRICT AND HAVE A PARENT WHO WORKS ON FEDERAL PROPERTY, AND "B" STUDENTS EITHER LIVE ON FEDERAL PROPERTY OR HAVE A PARENT WHO WORKS ON FEDERAL PROPERTY. FUNDING FOR "A" STUDENTS IS HIGHER THAN FOR "B" STUDENTS TO REFLECT THE ADDITIONAL TAX LOSS. FEDERAL IMPACT AID FUNDS ARE GENERAL PURPOSE REVENUES AND MAY BE SPENT WITHOUT RESTRICTION. THIS MEANS THAT THE FUNDS HAVE BECOME AN

INTEGRAL PART OF PAYING FOR EDUCATIONAL OPPORTUNITIES FOR ALL STUDENTS WITHIN A SCHOOL DISTRICT. WITHOUT THIS MONEY, SCHOOL DISTRICTS WOULD BE SEVERELY RESTRICTED IN THE OPPORTUNITIES THEY COULD PROVIDE TO THE YOUNGSTERS OF MILITARY PERSONNEL SERVING ON MILITARY INSTALLATIONS OR THE CHILDREN ON INDIAN RESERVATIONS THROUGHOUT THE COUNTRY.

ONE OF THE CONCERNS IN PAST YEARS IS TO MAINTAIN A HIGH QUALITY OF STANDARDS FOR ENLISTED MEN, AS WELL AS THE OFFICERS SERVING IN OUR ARMED SERVICES. ONE OF THE PRIZE "PLUMS" OF A DUTY ASSIGNMENT IS TO BE LOCATED WITHIN AN OUTSTANDING SCHOOL DISTRICT. YOU WILL FIND THAT IN MOST CASES THESE SCHOOL DISTRICTS ARE VERY DEPENDENT UPON IMPACT AID FUNDING, AND WITHOUT IT, WOULD NOT BE ABLE TO OFFER HIGH QUALITY PROGRAMS FOR THE CHILDREN OF OUR MILITARY PERSONNEL. THIS IS ONE PROGRAM WHERE THE FEDERAL GOVERNMENT AND SCHOOL DISTRICTS ARE ABLE TO WORK HAND-IN-HAND IN MEETING THE NEEDS OF OUR NATION.

I WOULD REQUEST THAT THE FEDERAL GOVERNMENT FULLY FUND IMPACT AID TO MAINTAIN THE QUALITY OF EDUCATION THROUGHOUT OUR NATION. IT IS IMPORTANT THAT ALL SECTIONS OF THE CURRENT LAW BE FUNDED AT FULL ENTITLEMENT. THIS IS ESPECIALLY IMPORTANT SINCE ENTITLEMENTS ARE BASED ON COSTS INCURRED TWO YEARS PRIOR. THEREFORE, FULL ENTITLEMENTS ARE BELOW THE CURRENT COSTS OF EDUCATION. IN FUNDING THE VARIOUS CATEGORIES, IT IS WELL RECOGNIZED THAT FUNDING OF "B" STUDENTS SHOULD BE SOMEWHAT LESS THAN THE FUNDING FOR AN "A" STUDENT. HOWEVER, THERE HAS BEEN A GREAT DEAL OF MOVEMENT IN RECENT YEARS TO FUND SUPER "A" DISTRICTS (DISTRICTS WHO HAVE 20% OR MORE OF THEIR STUDENTS QUALIFYING AS "A" STUDENTS) AT A LEVEL MUCH HIGHER THAN DISTRICTS WHO HAVE "A" STUDENTS BUT DO NOT

QUALIFY FOR THE SUPER "A" STATUS. THIS COULD MEAN THAT THE LOSS OF A SINGLE STUDENT COULD DROP A SCHOOL DISTRICT BELOW THE MAGIC 20% NUMBER AND LITERALLY RESULT IN THE LOSS OF SEVERAL MILLION DOLLARS IN IMPACT AID FUNDING.

I WOULD PROPOSE THAT ALL "A" STUDENTS BE FULLY FUNDED AT THEIR ENTITLEMENT LEVEL, AND THE "B" STUDENTS BE GIVEN ADEQUATE FUNDING TO MAKE THEM A VIABLE PART OF THE PROGRAM. IT IS FURTHER RECOGNIZED THAT SECTION 2 PAYMENTS SHOULD BE FUNDED AT FULL ENTITLEMENT.

WE ARE FACING A NEW CHALLENGE WITH THE PROPOSED CUTS RESULTING FROM THE APPLICATION OF GRAMM-RUDMAN. IN MY DISTRICT IN SOUTHERN CALIFORNIA, PARTICIPATING SCHOOL DISTRICTS WOULD FACE A LOSS OF $144,375 FOR THE 1985-86 SCHOOL YEAR, AND A FURTHER REDUCTION OF $1,138,976 FOR FY '87.

A GREAT DEAL CAN BE SAID ABOUT THE OBLIGATION OF THE FEDERAL GOVERNMENT IN WORKING WITH LOCAL SCHOOL DISTRICTS IN MEETING THE BURDENS OF TODAY'S HIGH EDUCATIONAL COSTS. IT IS IMPORTANT TO NOTE THAT THIS IS ONE OF THE FEW PROGRAMS, IF NOT THE ONLY PROGRAM, WHERE FEDERAL FUNDING GOES DIRECTLY TO SCHOOL DISTRICTS TO BE USED FOR STUDENTS AND VERY LITTLE MONEY IS PULLED OFF INTO BUREAUCRACY. (I'D LIKE TO NOTE THAT THIS ALSO WORKS TO THE DETRIMENT OF THE PROGRAM, SINCE THERE IS NOT A LARGE NUMBER OF CIVIL EMPLOYEES WORKING IN WASHINGTON TO LOBBY FOR THE FUNDS.) IMPACT AID IS GOOD FOR YOUNG PEOPLE AND GOOD FOR OUR NATION IN THAT IT PROMOTES THE STRONGEST FIBER OF OUR FOUNDATION: A HIGHLY EDUCATED POPULATION.

MR. CHAIRMAN, THANK YOU FOR HEARING MY CONCERNS, AND I URGE THAT IMPACT AID BE FUNDED AT ITS FULL LEVEL OF ENTITLEMENT.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. DUNCAN HUNTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. NATCHER. Our next witness is our friend and colleague from California, Mr. Duncan Hunter. Mr. Hunter, it is a pleasure to have you before the committee, and we will be pleased to hear from you.

Mr. HUNTER. Let me make a couple of statements and submit my statement for the record. I appreciate the opportunity to testify before you today on the subject of impact aid. I have testified with my colleagues many times before on the importance of impact aid to the 45th District of California, and of course, the entire San Diego and Imperial County community, and I hope you will continue to support this program.

My district includes all of the California-Mexican border. As a result of this, there is a great deal of Federal ownership of property, and particularly the Navy base, around the San Diego area, and a large number of Indian reservations, we have an enormous amount of property that otherwise would contribute to the tax base which has been withdrawn because of the Federal uses. Because of the presence of the United States Navy and the many Indian reservations, it has been estimated that if this property, was available for private use, it would involve many billions of dollars in value, that would be attributable to the tax base. The 45th District contains all types of impact aid categories, B students, Super A and Super B students.

The Coronado School District, serving the Naval Air Station, and the San Pasqual School District, are both Super A districts.

The South Bay Unified School District, serving the off-base military and civilian personnel, has an enrollment of over 20 percent Category B students from military families and from the families of civilian employees of the Federal Government. It is a very important part of our effort to upgrade the quality of life for our military families, and a very important part of that effort is played by impact aid that assures these kids, who move around the world on a regular basis and in the course of military rotations, have a quality education. And that education is very much a motivating factor in the decisions of military families and military people, and personnel to reenlist in our armed services.

So I would leave you with that message. Also it is extremely important to our Native Americans who occupy a number of reservations in the southern California area, and certainly this Congress is dedicated to upgrading the quality of life and education that these children receive.

I have never seen this room so empty, Mr. Chairman. I am sure you had 435 Members to go.

Mr. CONTE. They were here before you, Mr. Hunter.

[The statement of Mr. Hunter follows:]

CONGRESSMAN DUNCAN HUNTER

TESTIMONY BEFORE THE

SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION

MAY 6, 1985

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify before you today on the subject of impact aid. I have testified many times before on the importance of impact aid to the 45th district of California and I hope the subcommittee will continue to support this very worthwhile program.

As you know, my district includes the entire California-Mexican border. As a result, this requires federal ownership of property and the operation of government agencies that bring federal employers to the local communities. At the same time, the border creates a diverse multi-lingual and low income student population that places exceptional burdens on the local school districts.

In addition, my district contains the large Naval Air Station in Corōnado, the Naval Air Facility in El Centro, the Naval Submarine Base and several other military facilities. These facilities occupy some of the most valuable real estate on the West Coast. The district is further impacted by a large number of Indian reservations.

The 45th district contains all types of impact aid categories, A and B students, Super "A" and Super "B" students. The Coronado Unified School District, serving the Naval Air Station, and San Pasqual Unified School District, serving an Indian reservation by the Colorado River, are both Super A districts enrolling and housing students on federally owned property. The South Bay Unified School District, serving the off-base military and civilian personnel has an enrollment of over 20% Category B students from military families and from the families of civilian employees of the federal government.

South Bay has been at the bottom of all school districts in San Diego County in expenditure per pupil. The school district serves the border area and has large numbers of children from low income and non-English speaking families. If it were not for the receipt of Impact Aid funds as a Super B district, then the district would have had difficulty meeting the mandates of federal and state law to provide special services for their handicapped, non-English speaking students.

Mr. Chairman, I'd like to address a common misconception here in Washington that the community gains from Category B students because their parents pay local taxes. In fact, under the provisions of the Soldiers and Sailors Relief Act, military personnel may maintain a state of residence other than California and not pay state income tax. Also, the military family utilizes the major base commissaries and naval exchanges located on federal property where sales taxes are not collected.

Providing educational services for military dependents and others whose families are employed on federal property does create a burden on the local community. If all Category B students were funded at the current existing B entitlement, the school districts of the southern section of San Diego County would still not be comparable in wealth to those commuities that have civilian rather than federal employers.

In summary, Mr. Chairman, my congressional district is dominated by the federal government which owns a majority of the land and some of the most valuable properties. The federal government's activities are varied and necessary, but they do draw upon the community's services and I urge the Subcommitte to provide funding for impact aid.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. WES WATKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. NATCHER. We have our friend Mr. Watkins before us at this time. It will be a pleasure to hear from you.

Mr. WATKINS. Mr. Conte was mentioned several times this past weekend in Oklahoma. Chairman Bill Chappell and I were visiting a military base and he saw a number of different wildlife there. I told him I was working on trying to get Mr. Conte to come down there, and he said if I did, to be sure to put up all the cows, dogs, kittens, and all. But we saw a lot of game there.

This year, in Oklahoma and throughout that region, we are confronted with probably the most serious crisis confronting education that has ever happened. In Oklahoma we have a $700,000,000 shortfall in the State budget. We are cutting education more than 15 percent. Now, that is cuts.

We are confronted with the fact that many of our sparsely populated rural schools, with a great deal of our Indian population, do not have adequate funds from the State level. At this crucial time, impact aid is probably needed more than any other time, and I am not here to try to ask for a lot of new revenue.

I think many of us know we have got to try to hold the line in many of our areas, but in your wisdom, the wisdom of the entire committee, hopefully we can attempt to continue the funds at least at the levels we had in fiscal year 1986, so we will not have to erode a number of educational programs and lose those programs that are serving the population and the Native American population. We do not have reservation land, Mr. Conte, in Oklahoma, but many of the Indian families have their own piece of property. As a result, it makes the percentage of those in some of the schools have a major impact on that school system.

As a result, impact aid, needless to say, for our Indian population, is very, very crucial in keeping a school system going.

I grew up in an area with the Choctaw Indians, and I was the only non-Indian on the baseball team. I was the minority, because no one explained the normal definition of minority to us. I do know many of those people closely, and their dreams and their hopes, and I might say, one of the young people from my hometown had one of the highest ACT scores, an Indian boy going to SMU, and it is because of this kind of program that allowed him to get an education. He will be very much a contributing person to society.

So thank you for letting me come by and share a few of my thoughts.

Mr. NATCHER. Mr. Watkins, you have given us an excellent statement. We also appreciate your helping us when we bring our bill to the floor. Thank you very much.

[The statement of Mr. Watkins follows:]

Statement of

THE HONORABLE WES WATKINS

3rd District, Oklahoma

On

The Impact Aid Program

Before the

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,

EDUCATION, AND RELATED AGENCIES

of the

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

May 6, 1986

Mr. Chairman and distinguished members of the Subcommittee:

Thank you for allowing me the opportunity to testify before you today in support of the federal Impact Aid program. This program is essential to quality education in public schools in my congressional district, in Oklahoma, and across this nation.

Once again this year we received a budget from the Administration that proposed major program changes and funding reductions in the Impact Aid program. President Reagan's budget proposal would reduce funding to $548 million in fiscal 1987, as compared to the $662.7 million in funding made available for fiscal 1986 after the Gramm-Rudman cut was made to the $692.5 million Impact Aid appropriation.

I urge you to reject the President's proposals for further reductions in the Impact Aid program. I believe that schools adversely affected by the presence of the federal government deserve Impact Aid funding at the full authorization level, but in light of overall budget considerations, I urge you to try to hold strong to a freeze in funding at the fiscal 1986 appropriation level for the Impact Aid program for fiscal 1987.

The President's budget proposal would freeze funding for "A" children at the fiscal 1986 appropriated level of $513 million, but President Reagan has proposed a change in the distribution formula for "A" payments to benefit most those school districts where "A" children make up more than 50 percent of total enrollment.

The "Super A" category of funding currently provides 100 percent of entitlement funding to those schools with 20 percent or more of its students in the "A" category. While I recognize that Impact Aid is vitally important to these "Super A" school districts, I also recognize that creation of the "Super A" versus "Regular A" distinction has forced many schools in the "Regular A" category to suffer greatly financially (receiving only 33 percent of the authorized entitlement). Consequently, I cannot support the President's proposal to funnel the largest portion of "A" funding to schools with 50 percent or more "A" students, and urge you to reject it. If anything, I recommend that the justification for the distinction between "Super" and "Regular" categories for both "A" and "B" funding be re-evaluated.

The President's Impact Aid budget again this year proposed a total elimination of payments for category "B" children. As you know, the $130 million we appropriated for this category of the Impact Aid program for fiscal 1986 could hardly be called excessive -- it only provided funding for "Super B" schools at a rate equal to 60 percent of the authorized entitlement, and funding for "Regular B" schools at a rate of a mere 10% of the authorized entitlement. Yet, category "B" funds are vitally important to many schools across the nation.

I know from personal discussions with school superintendents and school board members in my congressional district that many small schools are heavily dependent on "B" funding to permit continued operation of the schools. Since I represent a 20-county area in rural Oklahoma, I represent many school systems in small towns and rural areas. If category "B" funding were eliminated, all of the 122 schools in my district that currently receive Impact Aid funding would be affected -- 26 schools districts would be dropped from the program and another 96 would lose a portion of their funding.

The total impact on Oklahoma schools if the President's budget proposals for Impact Aid are implemented will be a loss of $2.9 million, including a loss of $682,024 in "A" funding and a loss of $2,222,947 in "B" funding. Such a financial loss would strike an especially severe blow to public education in Oklahoma at a time when the state is experiencing severe economic problems.

Large across-the-board reductions had to be made in state spending in Oklahoma last year, the same year the largest tax increase in the history of the state was enacted. This year it appears that an additional 15 percent across-the-board reduction in state spending will be necessary. Every effort is being made to hold education budget cuts to 10 percent this year, but even if that is accomplished, many schools in Oklahoma are going to be on the brink of closure this year. Oklahoma schools are in desperate need of continued funding of federal education programs, as they will be unable to replace lost federal funds with state or local funds.

Federal education spending is an investment in the future of our nation's youth. Even in tight economic times we must invest in the education of our children. We have a choice -- we can pay for education now, or we can pay for the consequences in the future. The state of Oklahoma is doing its best to protect state education programs from severe budget cuts. I hope and pray you will again guide us to find a way to make that wise investment in the education of our youth on the federal level. In doing so, I urge you to look for a way to provide for the continuation of the federal Impact Aid program.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. IKE SKELTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. NATCHER. Our next witness is our friend and colleague from the State of Missouri, Mr. Skelton. Mr. Skelton, it is a pleasure to have you before the committee.

Mr. SKELTON. Thank you so much. I appreciate this opportunity to be with you and to testify before your subcommittee on the issue of impact aid for our schools.

We are all familiar with the history of impact aid and the important financial contribution that it makes in educating our children in areas where the Federal Government is a large property owner and military employer. Today, instead of talking generally about the importance of impact aid, I would like to submit for the record how important this program is to two school districts located in the Fourth Congressional District of Missouri, which I represent.

The Waynesville, Missouri, School District, located in South-Central Missouri, is responsible for educating approximately 4,600 students. Although a rural area, it is the home of Fort Leonard Wood, which will soon be the largest Army engineer training center in the free world. In light of the presence of Fort Leonard Wood, this region is the largest recipient of impact aid in the State of Missouri. Two-thirds of the total number of students are Army dependents and 80 percent of the student body is eligible for impact aid. Yet, despite the extremely large proportion of the school population which these dependents comprise, only about 30 percent of total funding to run the schools is generated from impact aid.

This leaves Waynesville and the State of Missouri shouldering the burden of 70 percent of the school budget for less than 40 percent of their students with little flexibility and ability to raise revenues. This is due to the large amount of area the Federal Government owns and the tax-exempt status of many military personnel.

Similarly, Knob Knoster School District, which encompasses Whiteman Air Force Base also in my district, is responsible for educating the military and Federal dependents of their area. Although 75 percent of the students there are federally connected and eligible for impact aid, the Federal Government contributes a mere 35 percent of the funding costs, placing once again a large burden on the community and State with few alternatives to raise revenue to meet the costs of educating their own children.

The towns of America who have supported military and Federal installations in their areas continually find themselves on the short end of the stick for funding during times when their own economies are depressed. My colleagues, these are but two examples of how the communities of this Nation are shouldering the burden which rightly belongs on the Federal Government. I hope that the Members of this subcommittee and all of my colleagues will see fit to bear a fair proportion of responsibility for this program during the upcoming appropriation deliberations.

This is a nutshell, a microcosm of smalltown America, and the effect of impact aid. I know the impact situation in the areas I mentioned are very significant, and we appreciate your kind consideration.

Mr. NATCHER. Mr. Skelton, thank you very much. We appreciate your statement. You have made an excellent statement. Thank you for appearing.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. BILL LOWERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. NATCHER. Our next witness is our friend and colleague from California, Mr. Bill Lowrey. Mr. Lowery, it is a pleasure to have you before the committee, and we will be pleased to hear from you at this time.

Mr. LOWERY. Thank you, Chairman Natcher and Mr. Conte, our ranking Republican Member on the full Appropriations Committee and Member of this subcommittee.

Mr. Chairman, when the cherry blossoms emerge around the Tidal Basin signifying the advent of spring, many minds daydream of warm afternoons, softball on the Mall, and evening performance at Wolf Trap. For me, however, when the blossoms bloom and thoughts turn to softball, I know it is time to pitch for impact aid again. Thank you again for the opportunity to present the case for impact aid.

I have appeared before this subcommittee on several occasions. This is now the sixth presentation, and each time have presented facts that remain virtually unchanged about the need for impact aid funding in my congressional district. San Diego, the home port of a quarter of the U.S. fleet and the center of Navy operation and training on the West Coast, is an impacted community. There are over 15 military installations within the San Diego school district's boundaries; consequently, the Federal Government is the largest employer and landowner, holding over 20 percent of city lands, and an even larger percentage of county lands. The Federal government utilizes this valuable property but provides little support for the federally dependent students' education other than impact aid payment.

This year, enrollment in San Diego City Schools includes 23,812 federally connected students. Of this total, 8,171 are Category A students—one of the largest concentrations in the country. This year, payments have dropped to 31.5 percent of entitlement for Category A students. Although San Diego Unified has always provided a high quality, complete educational program for the dependents of the military families who reside there, a continued decline in impact aid funding threatens this educational excellence. The school district is hopeful that this panel will work to ensure that A students are not underfunded in efforts to give 100 percent adjusted funding to Super As.

This academic year, San Diego also has 15,641 Category B students whose parents work on Federal property. Approximately half of these B families are civilians who live on taxpaying property and shop in stores whose owners pay taxes. However, over 7,000 are military dependents whose families can shop at post exchanges and commissaries which do not pay local taxes or collect State sales tax. This, as you know, lowers available resources for school districts throughout the State.

To highlight the problem such as San Diego has with a large number of B students, I offer the following scenario. If a family lives in Navy housing, the school district will receive $479 for this Category A student. If the family moves to civilian housing, the payment plummets to $24.89 because the student has become a B. Clearly, the difference between the two payments does not accurately reflect the burden carried by the district which must educate the youngster regardless of where he resides.

I might add, Mr. Chairman, in San Diego, we have a shortfall today of some 6,000 Navy families that desire naval housing, 6,000 naval families whose students are living in civilian housing, but who want military housing and the impact that that has upon the educational system.

San Diego has another unique problem: the combined impaction of A and B students totals 23,812 students or roughly 21.5 percent of the district's enrollment. While neither category reaches the 20 percent "super" threshold by itself, combined they top the 20 percent figure. I have raised this point the last few years in hopes that this panel might consider a unique funding formula for "Super A-B" districts such as San Diego.

Impact aid, unlike most Federal education programs, is current year funded. Therefore, the first year reduction under Gramm-Rudman affected funding for this school year. Each of the four categories—Super A, A, Super B, and B—were reduced by the same 4.3 percent. While painful for all impacted school districts, the equal reductions represented the fairest method of conforming to the strictures of Gramm-Rudman. Should a second sequestration take place for fiscal 1987, I urge that it be administered in the same across-the-category fashion as the fiscal 1986 reduction.

In closing, Mr. Chairman, I would like to reiterate that San Diego not only needs, but is entitled to receive impact aid in lieu of property taxes lost to federally occupied real estate. The local taxpayers' ability to subsidize the education of federally connected children is finite, and if impact aid is reduced, San Diego schools will be forced to cut staff and take other measures that will substantially lower the quality of education for all students.

Mr. Chairman, Mr. Conte, as a Member of the Appropriations Committee, I am prepared to work for maximum funding for this for this important program, and urge the subcommittee to do the same, as I know you have, and the consideration you have given to this issue in years past. Thank you.

Mr. **Natcher**. Thank you very much, Mr. Lowery. We appreciate your appearance. You have given us an excellent statement. Mr. Conte, I yield to you.

Mr. **Conte**. Mr. Chairman, I want to take this opportunity to compliment Mr. Lowery.

We will do all we can for him.

Mr. LOWERY. Syl, thank you. The 20 percent threshold is the key thing. San Diego is kind of neither fish nor fowl. We don't quite reach it alone with the A's, the Super A quality or alone with the Super B quality. But combined, as I mentioned this 21.5 percent, and I would hope that something like the Super A-B category could be established. I thank the committee.

Mr. NATCHER. Thank you very much.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. RICHARD H. STALLINGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

Mr. NATCHER. Our next witness is our friend and colleague from Idaho, Mr. Stallings. Come around, Mr. Stallings. We will be pleased to hear from you at this time.

Mr. STALLINGS. Thank you, Mr. Chairman. I certainly appreciate this opportunity to come before your committee and speak on behalf of the impact aid program. During the past five years, Federal funding for elementary and secondary education has dropped 7.2 percent in constant dollars. And now, at a time when the public is urging improvements in the quality of education, the Federal Government is becoming an increasingly minor partner in education.

For 1987, the administration proposes to reduce the Department of Education budget by approximately $3,200,000,000, or 17 percent, from the level appropriated for 1986. And once again, impact aid Part B has been targeted for elimination.

Given that real estate taxes are the main source of revenue for public school districts, I remain convinced that the Federal Government has a clear responsibility to assist school districts whose ability to generate tax revenue has been impacted by the presence of federally connected children and nontaxable Federal property.

In my home State of Idaho, approximately 64 percent of the land is federally owned. Two-thirds of the State is owned by the Federal Government. The Forest Service owns more than 20,000,000 acres of land. The Bureau of Land Management owns approximately 12,000,000 acres. The Bureau of Reclamation owns more than 446,000 acres. The Bureau of Indian Affairs owns more than 32,000 acres. The Air Force owns approximately 446,000 acres. The Idaho National Engineering Laboratory located near Idaho Falls employs almost 10,000 people, and more than 570,000 acres are owned by the Department of Energy. And the list continues.

Thirty-six out of 116 school districts in Idaho have made application for impact aid. The total enrollment for thee districts is 101,060 students, or 48 percent of the statewide enrollment in the 1985 school year.

For 1986, Idaho expects to receive $3,993,000 in impact aid funds. And to put this figure in perspective, Idaho only received

$32,250,000, or 6.2 percent of its total funding, for elementary and secondary education from the Federal Government during the 1985–1986 school year. One program, impact aid, composes approximately 12 percent of the Federal contribution to elementary and secondary education in Idaho.

And should a projected 23.6 percent across-the-board reduction become necessary in light of Gramm-Rudman, the impact on Idaho school districts would be disastrous. Idaho could lose in excess of $2,000,000 in 1987.

Already the State is facing a growing economic crisis, and school districts are not able to regain lost operating revenue through supplemental levy elections. In view of the current agricultural crisis facing Idaho, the majority of school district patrons simply can not support tax increases, so without impact AID, many of Idaho's school districts could be forced to close schools for lack of funds.

This source of revenue is critically important to Idaho's school districts, and to the more than 3,000 school districts across the nation whose ability to generate tax revenue has been affected by the presence of federally connected children. It is critically important that Congress enact a 1987 budget that provides funding for impact aid at the 1986 levels, and still comes within the $144,000,000,000 deficit target set by Gramm-Rudman, thus avoiding automatic sequestering.

Mr. Chairman, thank you for the opportunity to testify before this subcommittee. Impact aid is a vital program, and it has worked well over the years. It has provided increased quality education to hundreds of thousands of children, and I commend you for your efforts in behalf of this program and our Nation's children. I offer my support and will do what I can to help continue this very worthy program.

Mr. NATCHER. Thank you, Mr. Stallings. You have given us an excellent statement and we appreciate your appearance.

Mr. STALLINGS. Thank you.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. GERRY E. STUDDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. NATCHER. Our next witness is our friend and colleague in the House from Massachusetts, Mr. Studds. Mr. Studds, we will be pleased to hear from you.

Mr. STUDDS. Thank you, Mr. Chairman. You are so kind. I will leave my statement with you and give a very brief summary. I know that you have long days and difficult decisions, and increasingly so. The second year in a row, as you will recall, I have appeared before you in behalf of the small town of Bourne, Massachusetts, on Cape Cod. This time we have a specific plan, as I think you do know, offered by the Department of Education, and while I don't spend a great deal of time testifying on behalf of this administration's proposals in the field of education, I think they have in this specific instance a situation, a proposal which would correct the specific inequity in the category of Super As.

The town of Bourne, very briefly—I think the numbers will show what I mean. In 1983 it received all of its entitlement, over $1,000,000, which is very important for a small town because it exceeded the 20 percent threshold dividing Super from Regular. The following year, 1984, it lost a handful of its students, two percent of its enrollment, 50 children, and dropped to 17.7 percent. This resulted in a loss of almost $600,000 overnight of impact aid funds.

The same thing has happened in the succeeding two years. This year the number of federally connected students is up slightly, comprising 18.8 percent of the total. It is still below 20 percent, just barely; the town will get 31 percent rather than the entirety. The administration has proposed a six-tier graduated system for payment to towns rather than this cutoff to almost nothing. Districts with between 15 and 19 percent of federally impacted students, which would include the small town of Bourne, would get 75 percent of their entitlement under the administration's proposal.

For this little town, Mr. Chairman, this means over $500,000 more than it now receives. I know you have all kinds of hesitations and problems and difficulties which I trust you do with much of what the administration has proposed in the field of education. But in this instance it does seem to me that this proposal would restore a measure of equity which has been sadly missing for some small communities.

I want to thank you, Mr. Chairman, for both your attention in the past and particularly the distinguished senior Member from my own State who has spoken up so much so effectively for so many communities, including in this instance Bourne.

I thank you very much, sir.

[The statement of Mr. Studds follows:]

TESTIMONY OF CONGRESSMAN GERRY E. STUDDS

BEFORE THE

SUBCOMMITTEE ON LABOR - HEALTH AND HUMAN SERVICES - EDUCATION

OF THE

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

May 6, 1986

MR. CHAIRMAN. I would again like to thank you and your committee for providing me the opportunity to share my views on a program which is of special importance to several towns in my district.

One year ago I appeared before this panel to urge you and other committee members to modify certain provisions of the Impact Aid program which have resulted in serious financial hardship for many communities, including Bourne, Massachusetts. I am here again to make the same plea.

As you know, Congress a few years ago created the "Super" categories within the Impact Aid program. Under the law, if the percentage of federally connected students in a school system is less than 20 percent, the district receives in financial assistance only what is left over after the "Super" categories are funded. Because appropriations for the overall program have been reduced over the years, what is "left over" is not very much. The effect of this provision is that a school district with 20.1 percent federally connected students will receive 100 percent of its entitlement, while a district with 19.9 percent will receive only 31 percent of its entitlement. In my view, Mr. Chairman, this scheme, on its face, is grossly unfair and should be changed.

In the real world, where school superintendents must face daily decisions on how best to stretch tight school budgets, the existing distribution plan has created additional headaches for many school districts. A perfect example is the Town of Bourne, Massachusetts, which annually spends over $1 million educating the children of families who live and work on the Otis Military Reservation, and who pay no property taxes in support of this education.

According to Mr. Roland Brown, retiring this year after 15 years as the Town's Superintendent of Schools, Bourne has lost over $2,000,000 in Impact Aid payments in Fiscal Years 1984 through 1986. In those three years, the enrollment of federally connected students fell below the 20 percent threshold by 2.3, 1.7 and 1.2 percent, respectively. Consequently, the Town received less than one-third of its entitlement. In the current fiscal year, federally connected students comprise 18.8 percent of the school population. This is only 37 fewer students than required to meet the 20 percent level. As a result, Bourne's taxpayers will have to contribute $700,000 towards the education of federally connected students, whose parents pay no local property taxes.

This inequity would be resolved by the implementation of a significantly more equitable distribution formula for Category A payments proposed by the Department of Education. This new method of allocating Impact Aid funds continues to provide higher rates of payment for districts with high proportions of federally connected students. It contains, however, a graduated scale, with several stages at which payment rates would decrease. This is far preferable than the current system's abrupt funding dropoff when a district falls below the 20 percent threshold. Under the Department's proposal, the Town of Bourne would be paid 75 percent of its entitlement, over half a million dollars more than it now receives.

I strongly urge this committee to adopt the Department's revised distribution formula. While I do not support all other aspects of its 1937 appropriations request, I do believe that this Committee should seize this opportunity to correct a clear inequity in the administration of the Impact Aid program.

As I pointed out in my testimony last year, this program is not a "giveaway" of federal funds to local governments. The federal government has imposed itself on Bourne, Massachusetts, and many other communities across the nation, deriving such fundamental benefits as an education for the children of its workers while simultaneously reducing the local tax base. Simple fairness obligates the government to pay its fair share. I would argue, Mr. Chairman, that under the current distribution scheme, many cities and towns, including Bourne, are not now receiving their "fair share". I ask that you help ease the financial burden on these communities by endorsing the Department's proposal and including it in your recommendations for the Impact Aid program.

Again, I appreciate the opportunity to share my thoughts with you on this important issue.

Mr. NATCHER. Thank you very much, Mr. Studds. You have given us an excellent statement.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. JERRY LEWIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. NATCHER. Our next witness is our friend and colleague from California, a Member of the Appropriations Committee and a good Member of the committee. Mr. Lewis, it is a pleasure to have you before the committee.

Mr. LEWIS. Thank you very much, Mr. Chairman. As Congressman Studds suggested, you and your staff can read my statement rather than my reading it for you. I thought I would mention, however, that my district is most unusual in the sense that a former Member of our committee represented my district for many, many years a congressman by the name of Harry Sheppard. For half of the time that he was here he was the chairman of the Subcommittee on Military Construction.

Through the war years that led to rather incredible levels of military development in largely a desert district. Because of it, many communities in the area are very significantly impacted and thereby very importantly affected by the program that you are considering today. I would like to mention that Mr. Joe Randle is here, who is from the school board of the community of Adelanto. That community alone is some 60 percent impacted as a result of George Air Force Base, which really is the cause behind the development of the community in the first place.

Within that community, if it were to go forward with some of the projections of fiscal year cuts, Adelanto could lose as much as $600 per impacted youngster. It is very critical that we recognize the important role that this program has played, especially as it relates to our national defense and the families that are related to it.

I appreciate the work that you have done over the years. You have been more than helpful to my district and to those Members who are similarly affected, so we appreciate the efforts you are making. Thank you.

[The statement of Mr. Lewis follows:]

STATEMENT OF CONGRESSMAN JERRY LEWIS

BEFORE THE SUBCOMMITTEE ON HEALTH, EDUCATION AND WELFARE

COMMITTEE ON APPROPRIATIONS

TUESDAY, MAY 6, 1986

Mr. Chairman, as always it is a pleasure to be here today and to have the opportunity to appear before the Subcommittee to express my concern in the area of Impact Aid.

Since I first began testifying before this committee in 1981, I have become more and more concerned over the future of Impact Aid monies in California's 35th District. Since that time, PL 874 funding has decreased over 50% and projections under Gramm-Rudman Hollings for FY87 predict another 23.6% in reductions in an already extremely economically depressed situation.

As you know, Impact Aid monies supplement local school districts for monies lost from property tax revenues due to Federal acquistion of land. This is not a hand out, it is a debt clearly owed to the local school agencies by the Federal government. Due to the large number of military installations in my District, the school districts there are acutely aware of the importance of PL 874 monies. Silver Valley Unified, for example, relys on Impact Aid for 16% of their budget. A 23% cut would add up to over $280,000 for this small district. Adelanto School District has an enrollment that is 60% impacted. The projected FY87 cuts would add up to more than $600,000, more than $600 per Impacted student.

In addition, the even more severe cuts in PL 815 monies have prevented completion of new school building facilities in the Morongo Valley Disrict. The number of students that would be served has increased from 917 to 976 and an additional 200 homes are under construction in the area.

As a former school board member, I am acutely aware of what these kinds of reductions in funding can to do school programs. We cannot expect our educational system to produce a quality product if we do not provide them the means with which to do so. We must accept the responsibility of providing for the education of our children.

Mr. Chairman, your thoughtful response is appreciated and any consideration you can provide this matter will be very much appreciated.

Mr. NATCHER. Mr. Lewis, thank you very much. You have given us an excellent statement and we appreciate your appearance.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. EARL HUTTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. NATCHER. Our next witness is our friend and colleague from Florida, Mr. Hutto. Mr. Hutto, it is a pleasure to hear from you at this time.

Mr. HUTTO. Thank you very much, Mr. Chairman. I am grateful for the opportunity to come again before this distinguished committee to discuss a matter which is very close to the hearts and minds of your committee and many people in my district as well. You have already heard over and over today statistics outlining the damage which would be done if the administration's policy and funding proposals regarding impact aid are realized.

I will not repeat the numbers for the proposed cuts, dramatic as they are, since you have the chance to review them yourselves. Instead, I would like to give some flesh to these figures by describing for you the actual impact that these cuts will have on the citizens of Okaloosa County, just one of the counties in the First District of Florida affected.

A full 62 percent of the land in Okaloosa County is federally owned. Over half of the county, 52 percent of the land, comprising Eglin Air Force Base, a strategic installation that is geographically the largest Air Force base in the country. There are close to 9500 students, who are federally connected in the public schools in Okaloosa County, about 40 percent of the total student population. It requires no Albert Einstein to see that a school district cannot support itself under these circumstances unless there is some funding to compensate for the huge tax loss represented by governmentally owned property. The need for basic impact aid monies, as you can see are very great.

Of equal importance is that the monies which are appropriated for impact aid be equitably distributed. Specifically, it is mandatory that Funding for Category B students, as defined in Public Law 98-874, be continued. The Florida State Constitution prohibits the establishment of individual township districts. In other words, all school districts in Florida are countywide. This situation has made it extremely difficult for Florida counties to receive their fair share of the impact aid monies every year.

The size of our school districts precludes areas with even the largest bases from reaching Super-A levels because the highly impacted areas must be averaged with the rest of the county. In other parts of the country where they can have smaller school districts, city school districts, they would qualify for Super-A funds whereas we can't.

Mr. Chairman, we are all aware of the pressing budget decisions facing Congress, but this is not a welfare program, not a subsidy, not a supplemental program. Impact aid is a good-faith payment from the Federal Government to local governments in exchange for services rendered.

Mr. Chairman, if you will allow me to leave my complete statement with you for the record, I again would say thank you very much for what you have done through the years. We will appreciate working with you to continue impact aid funds that are so desperately needed by some of our school districts.

[The statement of Mr. Hutto follows:]

STATEMENT OF CONGRESSMAN EARL HUTTO
BEFORE THE SUBCOMMITTEE ON
LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION
HOUSE COMMITTEE ON APPROPRIATIONS
MAY 6, 1986

Thank you, Mr. Chairman. I am grateful for this opportunity to speak before you and the distinguished members of this Subcommittee about a matter which is very close to the hearts and minds of many residents in my district and across the nation.

You have already heard over and over today statistics outlining the damage which would be done if Administration's policy and funding proposals regarding Impact Aid are realized. I will not repeat the numbers for the proposed cuts, dramatic as they are, since you have had the chance to review them yourselves. Instead, I would like to give some flesh to these figures by describing for you the actual impact that these cuts will have on the citizens of Okaloosa County, just one of the counties affected in the First District of Florida.

A full 62% of the land in Okaloosa County is federally owned. Over half of the County -- 52% of the land -- comprises Eglin Air Force Base, a strategic installation that is geographically the largest Air Force base in the country. There are close to 9500 students who are federally-connected in the public schools in Okaloosa County, about 40% of the total student population. It requires no Albert Einstein to see that a school district cannot support itself under these circumstances unless there is some funding to compensate for the huge tax loss represented by governmentally owned property. The need for basic Impact Aid monies, as you can see, are very great.

Of equal importance is that the monies which are appropriated for Impact Aid be equitably distributed. Specifically, it is mandatory that funding category B students as defined in P.L. 98-874 be continued. The Florida State Constitution prohibits the establishment of individual township districts. In other words, all school districts in Florida are countywide. This situation has made it extremely difficult for Florida counties to receive their fair share of the Impact Aid monies every year. The size of our school districts precludes areas with even the largest bases from reaching Super A levels, because the highly impacted areas must be averaged with the rest of the county. In other parts of the country where school districts can be much smaller, often encompassing cities of varying size, it is no trouble to qualify for the Super category funds. If it were possible to divide Okaloosa county this way, the Niceville-Eglin-Valparaiso area alone would qualify immediately for Super A funds.

Mr. Chairman, we are all aware of the pressing budget decisions facing Congress. There can be no doubt that reductions must be made in all of our federal programs so that we may control our outrageous deficits. I have been consistently supportive of efforts to balance the federal budget, and I believe everyone must share to some degree in the burden of reducing our national debt. However, my convictions are just as firm that we cannot accomplish this goal at the price of providing for our truly poor and elderly, and of protecting and educating our children. Impact Aid is not a give-away program. It is not welfare, it is not a subsidy, it is not supplemental program. Impact Aid is a good faith payment from the federal government to local governments in exchange for services rendered. It is critical that the federal government keep its promises to the people that created and preserve it. Areas like those in the First District of Florida which are dependent on Impact Aid are not asking for total exemption from the belt-tightening that will have to occur. We are merely requesting an equitable system of reimbursement for our land and services so that our children can receive the finest education it is in our power to provide.

I am sure you will consider funding this investment in our future with great care. Please know that I stand ready to assist this Subcommittee in any way I can to prevent the draconian cuts now proposed from becoming embodied in law. Again, thank you for allowing me to appear before you today, and for your concern over this matter. I look forward to working with you on this important issue.

Mr. NATCHER. Thank you very much, Mr. Hutto. You have given us an excellent statement. We appreciate your appearance.

TUESDAY, MAY 6, 1986.

IMPACT AID

WITNESS

HON. LARRY E. CRAIG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

Mr. NATCHER. Our next witness is our friend and colleague from Idaho, Mr. Craig. Mr. Craig, it is a pleasure to have you before the committee. We will be pleased to hear from you.

Mr. CRAIG. Thank you very much, Mr. Chairman, for a chance to come and testify before your committee on this most important issue. Like my colleagues before me have said, I also appreciate the effort and the understanding you have had and demonstrated over the last good many years on this critical issue. I would also like to extend my appreciation to my colleague, the ranking minority Member, Mr. Conte.

You have heard from my colleague from Idaho, and I won't go into all of the details that I am sure he, in part, has provided to you. Idaho, unlike some States that are largely impacted by military installations, is truly impacted by the Federal Government in a different way. Sixty-four percent of our State is owned and managed by the Federal Government. As a result of that system of ownership and management, we find a great variety and degree of Federal impact. Interestingly enough, 46 percent of the total student population of the State of Idaho, attend schools in districts which are directly impacted by a Federal presence.

That is a very dramatic figure, Mr. Chairman. As you know I certainly stand as one of those individuals who believes in fiscal conservativeness and fiscal responsibility. In looking at this issue, I have pondered whether I am asking the Federal Government to do what ought to be the responsibility of the State of Idaho. However, when I look at Idaho's very small private land base that is taxable, and its very small population base, and compare it to the very large resource base that our Nation has, I do not believe we are asking too much. Apparently I am not alone in this belief since every . . . every presidential commission has reached the same conclusion since Public Law 874 was established. I hope that the committee will continue to recognize the difference between a Federal give-away program and this commitment on the part of the Federal Government to share in (educational) funding because of its involvement and presence in a particular area. I would suggest—and I am sure others have to this committee—that this is a program viewed by a good many citizens of our nation as just compensation to local units of government by the Federal Government for its adverse financial impact on particular areas.

In short, Mr. Chairman and Members of the committee, as you have often said, and as I know is true, the Impact Aid program is not a Federal giveaway. It is not something that the Federal Government decided to do to influence and/or change the course of events. It is designed to compensate for a Federal presence in a variety of States across the Nation, and certainly its substantial presence in Idaho. The Impact Aid program provides just compensation for that Federal presence and the subsequent impact that the Federal Government has in such an area. I feel it is necessary for the well-being of our Nation and for the State of Idaho.

Thanks so very much for a chance to come before your committee to offer this testimony, and I would ask that the totality of my testimony be placed in the record.

Mr. **Natcher**. Without objection, it is so ordered.

[The statement of Mr. Craig follows:]

MAY 6, 1986
CONGRESSMAN LARRY E. CRAIG
TESTIMONY BEFORE THE
HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HHS, & EDUCATION
THE HONORABLE WILLIAM H. NATCHER, CHAIRMAN

AFTER THE SECOND WORLD WAR, IT WAS REALIZED BY THE CONGRESS THAT IN MANY CASES, THE LOCAL DISTRICT'S ABILITY TO GENERATE REVENUE FROM PROPERTY TAXES FOR SUPPORT OF ITS PUBLIC SCHOOLS HAD BEEN SEVERELY REDUCED BY THE NATIONAL ACQUISITION OF NON-TAXABLE FEDERALLY OWNED PROPERTY. AT THE SAME TIME VALUABLE LANDS, BUILDING SITES, AND BUILDINGS WERE REMOVED FROM THE TAX ROLE, ADDITIONAL STUDENTS WERE LITERALLY SQUEEZED INTO SCHOOLS DESIGNED FOR MUCH SMALLER POPULATIONS. WHEN THIS PROBLEM WAS CALLED TO THE ATTENTION OF THE CONGRESS, IT WAS RESOLVED BY THE PASSAGE OF PL 81-874.

THE EXTENT OF IDAHO SCHOOL DISTRICTS' INABILITY TO GENERATE REVENUE DUE TO FEDERAL OWNERSHIP BECOMES CLEAR WHEN CONSIDERING THAT 64% OF THE STATE OF IDAHO IS OWNED BY THE FEDERAL GOVERNMENT. IN 1985, THERE WERE 36 SCHOOL DISTRICTS OUT OF 116 WHICH WERE FEDERALLY IMPACTED AND QUALIFIED FOR IMPACT AID. THE TOTAL ENROLLMENT FOR THESE DISTRICTS WAS 101,660 STUDENTS OR 48% OF THE FY 1985 STATEWIDE TOTAL ENROLLMENT. OUT OF THE 101,660 STUDENTS, 3% WERE SECTION 3 A STUDENTS AND 12% WERE SECTION 3 B STUDENTS. SINCE 80% OF THE IMPACT AID STUDENTS IN IDAHO ARE SECTION 3 B STUDENTS, YOU WILL UNDERSTAND MY CONCERN THAT THE PRESIDENT IS PROPOSING TO ELIMINATE THE SECTION 3 B CATEGORY IN HIS FY 1987 BUDGET.

THE SUBCOMMITTEE IS WELL AWARE OF MY COMMITTMENT TO REDUCE FEDERAL SPENDING AND TO BALANCE THE FEDERAL BUDGET. MY VOTING RECORD WILL DEMONSTRATE THAT I SUPPORT EFFORTS TO PREVENT CURRENT SOCIAL PROGRAMS FROM EXPANDING AND INCREASING IN NUMBER -- EVEN IF MY OWN CONSTITUENTS STAND TO GAIN SHORT TERM MONETARY BENEFITS. HOWEVER, IT IS ESSENTIAL THAT CONGRESS UNDERSTAND THE FUNDAMENTAL DIFFERENCE BETWEEN THOSE PROGRAMS AND IMPACT AID. IMPACT AID FUNDING IS **NOT** MONEY GRATUITOUSLY GIVEN TO ANY SCHOOL DISTRICT WHICH CAN DEMONSTRATE A NEED - RATHER IT IS MONEY GIVEN TO LOCAL EDUCATIONAL AGENCIES WHICH ARE DEMONSTRABLY AFFECTED BY A FEDERAL PRESENCE. THUS IMPACT AID IS FEDERAL **COMPENSATION** NOT ANOTHER FEDERAL GIVE-AWAY PROGRAM. EVERY PRESIDENTIAL COMMISSION ESTABLISHED TO STUDY PL 874 HAS RECOGNIZED THIS DISTINCTION AND RECOMMENDED CONTINUED FUNDING OF IMPACT AID.

SECTION 3 B STUDENTS ARE THOSE WHOSE PARENTS EITHER LIVE **OR** WORK ON FEDERAL PROPERTY. IMPLEMENTATION OF THE PRESIDENT'S RECOMMENDATION TO ELIMINATE THE FUNDING FOR CATEGORY "B" STUDENTS WOULD STEER THE FEDERAL GOVERNMENT ON A COURSE OF IRRESPONSIBILITY. CONGRESS HAS ALREADY DETERMINED THAT PARENTS OF "B" PUPILS WHO WORK ON FEDERAL LAND BUT LIVE ON PRIVATE LAND ARE HALF THE BURDEN ON THE LOCAL DISTRICT THAN ARE THE PARENTS WHO BOTH LIVE AND WORK ON FEDERAL LAND. IT SEEMS UNCONSCIONABLE THAT CONGRESS SHOULD FAIL TO FULFILL THIS DEMONSTRATED FEDERAL OBLIGATION.

STATISTICS INDICATE THAT IMPLEMENTATION OF THE PRESIDENT'S RECOMMENDATION WOULD DECREASE COMPENSATION TO IDAHO'S SCHOOL DISTRICTS BY APPROXIMATELY 55%. THIS COMES AT A TIME WHEN IDAHO'S DECLINING ECONOMY GREATLY REDUCES THE SCHOOL DISTRICT'S ABILITY TO RAISE TAXES THROUGH SUPPLEMENTAL LEVY ELECTIONS. I URGE THIS SUBCOMMITTEE TO CONTINUE TO FULFILL THE FEDERAL GOVERNMENT'S OBLIGATION TO FEDERALLY IMPACTED SCHOOL DISTRICTS BY CONTINUING TO FUND THE SECTION 3 B CATEGORY.

THANK YOU.

Mr. Natcher. Mr. Craig, you have given us an excellent statement. We appreciate your appearance before our committee.

Mr. Craig. Thank you.

Mr. Natcher. Mr. Conte.

Mr. Conte. Mr. Chairman, I want to join you in your statement. I had the experience, I should say good fortune, to spend a year in a hospital in Sun Valley during the war, and I know just what Larry is talking about. You said 60 percent of the land is owned by the Federal Government, and it's true.

I want to commend you for a very fine statement and for the way you work out there in Idaho. You are a credit to your district. We are proud of you.

Mr. Craig. Thank you, Mr. Conte.

His experience in Sun Valley, the nice part about that is that usually when people come to Idaho and experience our State, they always like to come back and on a regular basis.

Mr. Conte. I almost didn't leave there.

Mr. Natcher. Thank you very much.

The committee will now adjourn until 11 o'clock tomorrow.

IMPACT AID

[The following statements were submitted for the record:]

STATEMENT BY REPRESENTATIVE DON SUNDQUIST
before Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education
May 6, 1986

Mr. Chairman, and distinguished members of this subcommittee, I appreciate the opportunity to offer testimony today in support of continued funding for Impact Aid (Public Law 81-874), particularly Category B.

The second largest school system in my congressional district, Clarksville-Montgomery County, has become extremely dependent upon receiving impact aid funds. Because of the county's ties to Fort Campbell, the intent of this aid is certainly justified. The loss of revenue resulting from the tax-free federal property of Fort Campbell, as well as other tax exemptions afforded the military, obviously must be gained through other sources. Impact aid is the only fair vehicle for this revenue to be provided.

In Montgomery County, 43,000 acres of property have been removed from the tax rolls as a result of Fort Campbell's. existence. As you can well imagine, it would be very difficult to ascertain the true taxable value of this property if it were not federally owned. But if the average value of other land in the area is applied, the estimated taxable value of the base's property is $32 million. This would in turn produce $688,000 in revenue to the schools in the county. The local tax base for schools is predominately made up of three sources: the property tax, the sales tax and the wheel tax. One can thus estimate additional lost revenue. According to the most recent information available, total sales in 1985 exceeded $70 million at the Fort Campbell PX and Commissary. Since the base is located on the state line between Tennessee and Kentucky, it is impossible to ascertain the actual percentage of sales made in Tennessee. If one assumes that half of the sales had been made in our state and were subject to local sales tax, Montgomery County would have received $787,500 in revenue to the school system. Also, according to the most recent information available, there are 22,380 private vehicles registered to military personnel in Montgomery County. If these vehicles were subject to sales tax and wheel tax, another $447,600 would have been gained.

Apparently, an exact assessment of the lost revenue cannot be made. But it is obvious that the school system is financially "impacted" by the loss of revenues.

In discussing this problem with Clarksville-Montgomery County school officials, I have learned of additional considerations -- specifically, an extremely high turnover of students. Each year, more than 2,500 students transfer out of the system and are replaced with new enrollees. While this situation is to be expected in any school system near such a major military installation, it is nevertheless a nightmare for local school officials. Accurate planning and staffing is difficult, if not impossible. Special programs and attention to military students is also necessary, and expensive.

For these reasons, I urge you in the strongest terms possible to reject the Administration's proposed elimination of Category B of Impact Aid. The reductions in this program's funding since the 1980-81 school year have put many school systems in the country in budgetary dilemmas. I believe it is unfair to ask these school systems to absorb further reductions. These schools are faced with tremendous challenges in educating the children of those serving in our nation's military forces. They've done an outstanding job with minimal assistance from the federal government. I believe it is our duty in Congress to provide them adequate funding so they can continue their efforts.

Thank you for this opportunity to state my views before this committee.

Testimony-Impact Aid, Congressman Charlie Rose, Seventh Congressional District, North Carolina

Presented to The Subcommittee on Labor, Health and Human Services, Congressman William N. Natcher May 6, 1986

Mr. Chairman and Members of this distinquished committee, I appreciate the opportunity to appear before you to present testimony supporting Impact Aid.

As you know, Public Law 874 authorizes the payment of funds for the maintenance and operation of public schools in federally affected areas, and it is the critical need for continuation of this funding that is of utmost concern to my school districts, and to the many others who are depending so heavily on Impact Aid for essential operational support.

Since revenues from local property taxes are crucial resources for education, the location of federal property in a community inherently creates a tax-loss situation, and denies much needed income to the local schools. PL 874 was intended to address the financial need of school districts because of the location of non-taxable property, and high influx into these areas of federally connected persons whose children must receive educational services. This situation creates a lower local tax base while, at the same time, it establishes an increased need for educational services for children. Impact Aid reimbursement to the Cumberland County Schools has been, and remains, critical to a quality education for the children of our community.

On July 1, 1985, the Cumberland County Schools and Fayetteville City Schools merged to constitute the Cumberland County Schools with a student enrollment of 43,500. The merger of the two school systems accentuates the need for continued Impact Aid Funding. In this first year of merger, 16,781 students are classified as "B" students whose parents reside off the federal property but work on federal property, or students whose parents only reside on federal property. 857 students are classified as "A" category because the parents reside and work on the federal installation. Based on this count and the 1984-85 funding formula, the Cumberland County Schools would be entitled to approximately 2.7 million dollars for 1985-86. If these funds are reduced or lost, a local tax increase and/or a decrease in services would be required.

Also, I should mention that in Cumberland County, quality education is indeed a bargain. The Per Pupil Expenditure for 1984-85 for the Cumberland County Schools was $2,358.78. This is compared with the Per Pupil Expenditure of $3600 for educating a child on the Fort Bragg Military base.

In summary, I wish to again stress our continuing need for Impact Aid, based on the following critical reasons:

1. The federal government is a non-tax-paying employee of major extent in Cumberland County.
2. The cost of exemption of federal property from tax rolls must be assumed by local taxpayers unless other federal support is received.
3. Impact Aid funds directly benefit the federally connected children.
4. The Impact Aid program is an efficiently administered program.
5. The Cumberland County Schools depend heavily on Impact Aid funds to assure quality teachers through salary supplements and to provide necessary instructional materials, supplies, and services.

I urge you to act decisively by strongly recommending a fully funded Impact Aid Program. Your concern for children will be appreciated.

STATEMENT BY REPRESENTATIVE MICKEY EDWARDS BEFORE THE SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION OF THE HOUSE COMMITTEE ON APPROPRIATIONS

MAY 6, 1986

Mr. Chairman and distinguished members of the subcommittee, I appreciate the opportunity to come before you today to express my support for funding for the Federal Impact Aid Program.

This year, as always, we are being contacted by various groups wanting to protect this or that special interest from budget cuts. Impact Aid funding represents a special interest too -- a special interest in our children who have always been a special priority in our country, and should continue to be so.

I applaud the efforts of our President and this Congress to eliminate wasteful government spending and to balance our budget. However, by attempting to reduce funding for Impact Aid again, we are not cutting fat, we are cutting into muscle.

Mr. Chairman, states with large populations of impact aid children should not have to assume the additional burden of paying for the education of children whose parents, by federal law, are exempt from paying part, or all, of the state taxes our school districts depend on.

Oklahoma has a high percentage of federal employees and a significant Indian population. Department of Education figures for FY 1985 show that, in my district alone, 3,530 students, 5.1% of our total school population, came from federally connected families. With our current depressed farm economy and the continuing crisis in the energy industry, Oklahoma simply can't afford to subsidize the educations of all these children without federal impact aid assistance.

Mr. Chairman, the Department of Education lists nine school districts which are totally, or partially, within my Congressional district. They received a total of $88,781 in impact aid funding for FY 1985. These school districts have already been asked to absorb cuts in this funding and are paying more than their fair share for their impact aid students. The elimination of funding for "B" children, as proposed in the President's budget, would be devastating for these districts. Eight of these school districts would lose all of their federal assistance should funding for "B's" be eliminated. In FY 1985, the elimination of funding for "B's" would have resulted in a loss of $83,729 -- a 94% decrease in assistance.

The loss of these funds would not just be unfair, it would be a serious blow to the ability of these schools to offer a quality education to the children of Oklahoma.

I ask you to retain funding for category "B" students, and to continue providing the necessary Impact Aid funding our State desperately needs if we are to provide our children with the education they deserve.

Thank you.

STATEMENT BY

CONGRESSMAN BYRON L. DORGAN

North Dakota

Subcommittee on Labor - Health and Human Services - Education

May 6, 1986

MR. CHAIRMAN, I want to thank you for holding this hearing on Impact Aid, an education program that is vital to so many of our school districts.

Once again, I find myself speaking out in strong opposition to the Reagan Administration's misplaced budget priorities and once again I am speaking out in strong support for continued funding for the Impact Aid program.

Impact Aid is not an "Indian" problem. It is not a "Military" problem. It is not a "local" problem. Impact Aid is an issue of fairness and equity to the children and school districts all across the country. It is the basic obligation of the United States government to provide financial assistance to those school districts which have a substantially reduced tax base because of the federal government's presence in their area. More than 3,000 school districts in this country receive Impact Aid; more than one fifth of all students attend impacted schools. To expect the local communities to meet all the expenses of educating children whose parents do not significantly contribute to the local tax base is simply unfair.

Clearly the Reagan Administration does not understand those simple, indisputable facts. The Administration's fiscal year 1987 budget proposes to cut $132 million from the Impact Aid program by eliminating reimbursement to schools with category B students - those whose parents live OR work on federal property. This proposal comes after the Impact Aid program has already absorbed a 4.3% cut from Gramm/Rudman/Hollings and a total reduction in funding over the past five years of 50%. One could certainly argue that the program has taken more than its fair share of budget cuts.

Funding for "B" students has continually come under fire. There is no justification for the argument that without Impact Aid, "B" students would not be a burden to the local economy. If "B" payments cease, the unquestionable result will be a decline in the quality of education for all students in that community. When possible, school districts will be forced to unfairly shift a greater portion of the tax burden to non-federally-connected taxpayers and, in many cases, forced to discontinue services. As undesirable as that transfer is, many school districts, such as the Fort Totten district in my home state of North Dakota, will not have that option; Indian reservations simply do not have the additional funds to draw upon.

The President's budget request does not limit its cuts to the "B" program. The Administration would also limit the construction grant part of the Impact Aid program to $5 million despite the fact that there are over $500 million in unpaid needs. Their justification for this is the claim that there are additional construction monies in the Defense Department budget. Because the Defense Department can only build schools on military bases for military children in areas where the local community has no school system, any construction funded by DOD would still be grossly inadequate.

In summary, Mr. Chairman, I thank you for holding these hearings and urge your continued support for a strong federal Impact Aid program.

TESTIMONY OF CONGRESSWOMAN BARBARA BOXER
BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE
ON LABOR - HEALTH AND HUMAN SERVICES - EDUCATION

APRIL 24, 1986

Mr. Chairman, I appreciate the opportunity to submit testimony before the Subcommittee on an issue which is so vital to the schools in the 6th Congressional District of California.

My District has a number of federal installations including Mare Island Naval Shipyard, Hamilton Air Force Base, Golden Gate National Recreation Area, and the Army Presidio of San Francisco. Although these facilities and their federal employees provide incalculable assets to the district's economy and culture, they also have a negative effect upon the local tax base which is the life blood for the affected school districts.

Federal Impact Aid, as mandated in P.L. - 874, is intended as payment to local school districts for the cost of educating the children of federal employees who are exempt from contributing local property taxes. The concept is simple and fair. Anything less would be irresponsible on the part of the federal government.

And yet federal irresponsibility in regard to Impact Aid has run rampant. The program has suffered a 50% cut since 1981. Add to that the 4.3% cut due to the Gramm-Rudman Defecit Reduction Act, and the federal government is getting away with paying less than half of what it should rightfully be paying impacted schools.

What does all this mean to the school districts involved? I would like to share two examples:

1) The Novato Unified School District received just over $1 million dollars in 1981 to compensate for the 1500 students from Hamilton Air Force Base. In 1985, they were payed $504,710 for 1425 students. They were entitled to more than $2 million dollars!

Consequently, the school district has been forced to drastically curtail educational services during the past five years. Four schools ~~have~~ closed; the teacher force has been reduced; class sizes have increased; major maintenance and capital improvement programs have been eliminated; and the list goes on

2) Mare Island Naval Shipyard occupies prime commercial land along the waterfront in Vallejo, California. The assessed value of this land can be estimated by using the assessment of the nearby Benicia Army Arsenal which was closed and developed as an industrial park.

By this estimate, the 1974-75 tax rate of $4,491 in the Vallejo City Unified School District would have raised $4,782,600. The actual figure raised that year was $1,292,291. The potential difference of over $3 million dollars is equalvalent to almost 20% of the school district's annual budget.

Taking the same estimate, along with the current number of students and considering the state limits on revenue per student, we find that an additional $5 1/2 million dollars could have been received in 1985-86 had Mare Island been taxable property. Instead, under the provisions of P.L. - 874, approximately $700,000 will be received. This is a discrepency of nearly $5 million dollars in the current school year alone.

I present these examples to make two points: 1) The impact of non-taxable federal lands on local school districts can be overwhelming; and 2) The federal government has a responsibility to compensate those school districts so that federal presence in the community does not negatively affect quality education.

Mr. Chairman and members of the Committee, this issue is not a matter of how much we should cut. We have no right to reduce a fiscal obligation to local communities for the services they are providing our federal employees. The federal government does not unilaterally reduce its electric or gas bill or other services it receives from the private sector.

Consequently, Impact Aid should be exempted from the 4.3% cuts mandated by the Gramm-Rudman Deficit Reduction Act, and funding should be maintained at least at the current level. In time, we should restore funding to Impact Aid that fairly reflects the fiscal impact that federal installations have upon local entities.

I ask that you keep fairness in mind as you give thoughtful consideration to the continued funding of Impact Aid.

Thank you very much for the opportunity to submit my statement.

Statement of Representative Dave McCurdy
on P.L. 81-874 (Impact Aid)
The House Committee on Appropriations
Subcommittee on Labor-Health & Human Services-Education
April 24, 1986

Thank you for this opportunity to submit testimony in support of the Impact Aid program.

The administration has proposed certain reductions in the P.L. 81-874 Impact Aid program. Of particular concern is the proposed elimination of Category "B" students.

Without Category "B" funding, 91 of the 327 school districts in the state of Oklahoma will no longer qualify for any impact aid funding. Another 259 will lose a significant portion of their funding. Of the 91 districts to be eliminated from the impact aid program, 16 are in my congressional district. The total loss to the state of Oklahoma will be $2,903,971. This is approximately 15% of the total impact aid budget which the state currently receives. The total financial loss to my district is estimated to be $1,254,406.

Category "B" students impose a significant financial burden on a federally impacted local community. In Oklahoma, where state revenue is dropping rapidly because of the oil and agriculture crises, every federal dollar for education is increasingly important. Oklahoma is one of the three states in the deepest financial crunch.

Community economic growth, which is currently almost non-existent in my state, is not a trade-off for Category "B" payments. With economic growth comes an influx of new employees to a community. They bring with them their own children to be educated. The accompanying increase in the tax base simply pays for the education of the new employees' children and not the children of federal employees working on tax-exempt property.

The required mobility of many federal employees results in a disproportionate number of children in need of special services. Students from these families often miss as much as two months of school with each move.

Impact aid is not a program in which the federal government mandates educational criteria for the public schools to meet. Impact aid promotes local control and allows money to be distributed directly to local units to use as needed. It integrates federally connected students into classes with other students and lessens community resentment of federal and military personnel. It also has among the lowest administrative costs of any federal program.

Impact aid was created to ensure that the children of federal personnel would have access to an equitable education program without placing an unjust tax burden on local taxpayers. The reasons for establishing impact aid are just as valid today as they were in 1950, when the program was started. State and local school districts are not trying to neglect their responsibilities; they are doing everything they can to finance education. Some local districts have proposed that tuition be charged to federally connected students or that they be barred from school because they are a drain on local resources. The pursuit of excellence in education depends on every part of the community, including federal employers, paying its fair share for the education of our children.

TESTIMONY

on behalf of the

IMPACT AID SCHOOLS

BY

The Honorable James R. Jones
Congressman from Oklahoma, District 1

before the

Subcommittee on Labor, Health and
Human Services, Education

Committee on Appropriations

April 24, 1986

Mr. Chairman, Members of the Committee:

Thank you for giving me this opportunity to have my written testimony in support of Impact Aid inserted into the record of this hearing.

During World War II, many school districts throughout this country faced financial difficulty because of the heavy impact of students from federal installations and other tax-exempt property. Federal activities which involved the removal of real property from the local tax rolls caused a sudden and substantial increase in the population of many American communities. As a result, many school districts throughout the nation found it extremely difficult, if not impossible, to maintain and provide the necessary facilities and services for public education. It suddenly became the responsibility of those citizens already established in the neighborhood to pay significantly higher taxes to subsidize the children generated by these federal properties; to subsidize unfairly and disproportionately an obligation which should be shared by the entire nation.

To aid these districts in meeting these problems, Congress, early in 1941, approved the Lanham Act which provided federal assistance for the construction of school facilities and the maintenance and operation of schools in areas overburdened by reason of the increased federal activities. While this program was designed as a war measure only, the situation of these affected areas was such that continued federal assistance was essential.

In 1950, a congressional committee was appointed to determine if a continued burden had been placed upon these schools and if there was need for continued federal funding. This committee visited schools throughout the United States and was shocked at the growth of so many school districts and the inadequacies of housing for the children. This committee recognized that not only was federal property removed from the tax rolls, but that the federal activities had caused many school districts to have a tremendous increase in enrollment. The committee also recognized that these federal activities were indeed a continuous burden on the school districts. It became equally evident that children being educated on Indian land and from federally-owned, non-taxable Low Rent Housing Units also represented a severe tax burden.

Public Laws 81-874 and 81-815 were, therefore, written and approved by Congress based on an entitlement similar to an "in lieu of" tax. The general philosophy behind Impact Aid was to aid local school districts in educating children whose parents lived or worked on federal property. Since this property is not subject to local taxation, the financial burden had to be shared by the state and federal governments.

Current law recognizes that local school districts are dependent upon tax revenues from (1) residential property of individuals; (2) commercial and industrial property; (3) sales; (4) income; and (5) license and fees. Accordingly, the Impact Aid law now establishes two main categories of section 3 pupils:

1. Pupils who reside on federal property with a parent

working on federal property; or who reside on Indian land; or who reside on federal property with a parent on full-time active duty in the uniformed services - "A" pupils.

2. Pupils who reside with a parent on federal property or low rent housing; or who reside with a parent working on federal property; or who have a parent on full-time active duty in the uniformed services - "B" pupils.

This program is funded through a weighted entitlement system which authorizes payments for various subcategories of pupils. Consequently, Category "A" (Military "A" and Indian land pupils) is the one with the greatest funding allocation. Category "B" payments are funded at a lesser amount in recognition that school districts receive "some" tax benefit from the homeowner.

Since the congressional committee's investigation in 1950, there have been three additional studies of the Impact Aid program: (1) The Stanford Report, (2) The Battalle Report, and (3) The Report of the Commission on the Review of the Federal Impact Aid Program (established by law). These three Presidential Commissions, all designed to discredit Impact Aid, have, in contrast, endorsed the law and its funding. As recently as 1978, President Carter spent over $1,000,000 on a commission with the intention of eliminating Impact Aid only to find that this commission developed an understanding of Public Law 81-874 and recommended its expansion. In 1980, the Commission issued an interim report stating, in part: "The Commission finds that...

any reduction in the level of appropriations of P.L. 874 will cause serious disruptions in the operation of many schools, and, in the case of the more heavily impacted districts, school closings, (and) that the basic premises of the program have validity today and will continue to have validity until there is a major change in structure of financing public education"* Is not anyone reading this report? How many times must it be validated before it is fully funded?

Over 3,000 school districts in the nation are now eligible for Impact Aid funding, including 327 in the state of Oklahoma. The money is paid directly to the school districts as general non-categorial aid and there is little loss in the administration of the program.

The President's budget would eliminate all category "B" school districts from Impact Aid funding. In my own state, the 327 districts eligible for Impact Aid funding, eight of which are in my congressional district, have an entitlement of almost $19 million. Reductions in category "B" funding will completely eliminate 91 districts statewide, and severely affect another 168 of our 327 applicant districts. In my district, over 94% of the students are category "B", and three applicant districts would most likely be eliminated altogether. We project at least a $2.9 million reduction statewide in funding this year. These reductions will cause education services to diminish, personnel cutbacks, increased taxes where permitted and possibly some school closings. This would occur at the same time the state of Oklahoma is forced to cut its education budget approximately 15%. We can not sustain such a double blow to the future of the children of our state.

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* Interim Report, Commission on the Review of the Federal Impact Aid Program, 1981.

The importance of Impact Aid is one of the finest examples of Congress supporting local efforts to solve local problems. Because these funds are under minimum federal control, they allow local boards enough flexibility to solve specific problems which Congress might not recognize. This is the value of the Impact Aid Program; it helps support the total education program.

The problem which compelled Congress to establish this program in 1950 still exists today. Federal land holdings continue to reduce the local tax base; federal employment continues to cause great fluctuations in local school enrollments, and the local school district continues to suffer as a result. Mr. Chairman, 54% of the school districts in Oklahoma are affected. Impact Aid is a reasonable solution to a federally caused problem. It is in every sense of the word the best bang for the federal buck. Absorbing a federally connected child into a public school system is cheaper by as much as 50% than educating the same child in a "military" or "Indian" school.

There are some basic problems concerning Impact Aid. One problem has been the Executive Branch's persistent refusal to acknowledge the federal obligation to the communities affected. Why this is true I do not know. School officials have tried time and again to open dialogue with civil servants and administration appointees. These attempts have been unsuccessful.

This refusal of the Executive Branch to acknowledge the existence of the federal obligation to affected schools is the heart of the problem. The ultimate decision you face in this committee, and we all face on the floor of the House, is whether the federal government owes a responsibility to the nation's schools affected by federal activity. The answer to this question is fundamental to all others regarding Impact Aid.

It seems that as certainly as there will be a federal budget proposed each year, included in that budget will come a call for the reduction of Impact Aid funding. A recurring theme heard in Washington by those who would like to cut Impact Aid is that we all must share in reducing the multibillion dollar federal deficit. This Congress is rightly concerned with reducing the federal deficit. But, we must carefully consider all proposed cuts to ensure that worthwhile, effective and operative programs do not fall victim to reckless savings which could do more damage than good to the American taxpayer.

Impact Aid is one of these worthwhile programs. We can not afford to lose this outstanding model of cooperation between Congress and the people; and just as important, the local school districts can not afford to lose this important source of revenue. We are not asking for a substantial increase in funding; we are asking that Impact Aid not sustain any more cuts.

Thank you for giving me the opportunity to share my thoughts with you. I trust that my testimony will help convince you of the necessity of continued funding for all sections of the Impact Aid program.

STATEMENT BY JAMES V. HANSEN

BEFORE THE

SUBCOMMITTEE ON LABOR--HEALTH AND HUMAN SERVICES--EDUCATION

HOUSE APPROPRIATIONS COMMITTEE

MAY 6, 1986

Mr. Chairman, I am pleased to submit testimony in support of funding for Impact Aid.

As you know, real estate taxes are the main revenue source for public school districts. Public Law 81-874, Impact Aid legislation, was enacted in 1950 to help those school districts that were unable to generate tax revenues because of the presence of federally-connected children and non-taxable federal property. The law simply states that it is "the policy of the United States to provide financial assistance to those local educational agencies which the United States has placed a financial burden."

In the State of Utah, Impact Aid is of utmost importance. Over 40,000 school-age children qualify as Category A and B students. In one school district, Tooele County, 46 percent of its students are Impact Aid children. This heavily impacted school district shows real evidence of financial burden from lost revenue from property due to federal activity.

In addition to Tooele School District, there are a number of other areas in the First district which I represent where Impact Aid students account for almost 30 percent of all school-age children. For example, 28 percent of Weber County School District children are Category A and B students; there are 23 percent in Ogden City; and 21 percent in Davis County. I know that in other parts of the state the percentage is just as high, or higher.

Mr. Chairman, Impact Aid is not a supplemental program. It's based on real costs to school districts that must educate federally-connected school-age youth. If school districts cannot generate revenue from non-taxable property or from the parents of children who are employed on federal property, I ask where do we suggest they turn for financial help if not Impact Aid?

Can the Congress rationalize a higher tax on non-federal families in order to pay for the education of federally-connected children, some of whom contribute practically nothing to the tax support system? I don't think so. This rings particularly true in light of three Presidential Commission studies that have validated the federal government's obligation to those public school districts educating federally-connected children. How many more studies will it take before the importance of Impact Aid is fully understood?

The President's Fiscal Year 1987 budget has proposed the elimination of Category B children. It is important that the Congress carefully examine the impact that federally-connected children have on our schools when deciding on funding for Impact Aid. If funding for Impact Aid is not appropriated, I suggest that our school districts be allowed to tax federal property.

I urge that we work together to make Impact Aid happen. It's time to stop building barriers of misunderstanding and start building bridges of understanding.

TESTIMONY OF THE HONORABLE VIC FAZIO
HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

Mr. Chairman, Members of the Subcommittee, I would like to thank you for this opportunity to testify in support of the impact aid program, a program vital to the schools and students in my congressional district.

We are all well aware of the budget constraints with which we are faced this year and the fact that many difficult choices will have to be made. As a member of the Appropriations Committee myself, I know that there are a great many programs which deserve our commitment yet face reductions because of the deficit. On the other hand, certain programs necessitate our continued commitment. Impact aid is one of these programs.

The money spent on impact aid is well worth it. Impact aid fulfills a debt that the federal government owes to the affected communities. While the presence of federal installations in local communities is positive in terms of providing job opportunities and contributing to the local economy, in one important sense it has an adverse impact. The school districts that include federal installations are faced with the challenge of educating more students while receiving less financial support through local property taxes, residential taxes property taxes paid by the students' parents, and the worksite property taxes paid by the employer. The federal impact aid program is, therefore, vital in shoring up the eroded tax base which would have funded these school districts. Since most school districts across the country rely heavily on property taxes, the school district with federal installations is heavily reliant on impact aid.

For example, in Solano County, more than 12,000 students are designated federally connected. The County has two major employers, Travis Air Force Base and Mare Island Naval Shipyard, both of which are exempted from property taxes. These large federal holdings dramatically inhibit the school districts' ability to raise revenues while dramatically increasing the burden on the school districts. Land owned by Travis Air Force Base, for example, has been assessed at more than $2.65 billion. Further, in fiscal 1986, Travis has an operation and maintenance budget in excess of $42 million. Yet these resources do not contribute to the school districts' revenue base, as they would if these properties were owned by the private sector. Impact aid, therefore, has been critical to offset this lost revenue.

Impact aid monies have also made significant contributions to educational opportunities in Solano County. These funds have been instrumental in planning and implementing excellent programs that could not have been planned by low-income producing districts which do not have the benefit of the impact aid monies. For instance, without these funds, Solano County as a whole could not have produced and gained national recognition for excellent special education classes for the physically handicapped and mentally retarded students.

I also would like to point out the necessity of the continuation of the of the category B students, those students whose parents either live or work on federal property. As you know, the administration has proposed the elimination of one category of "B" children. It has proposed cutting $130 million and the resulting elimination of federal assistance to over one million children. These children are already a severe undercompensated financial burden on school districts all over the country. Elimination or reduction of funding would be devastating.

I would also like to comment on the devastating cuts impact aid has already suffered as a result of Gramm-Rudman. For example, Travis Air Force Base has suffered a $300,000 reduction. Any further cuts in the program will seriously undermine the ability of school districts to adequately meet the students of federally connected schools.

Mr. Chairman, Subcommittee members, I urge your support for the highest possible funding for impact aid. We cannot afford any further diminution of impact aid funding. As we seek to improve the quality of education in our nation's schools, the curtailment of our commitment to impact aid will severely affect our ability to ensure that every American child receive a quality education. We must meet this federal obligation and commitment. We in Congress cannot afford to fail in our assistance to local school systems in the education of federally connected students.

Statement by

Representative John M. Spratt, Jr.
Fifth District, South Carolina

Before the

Subcommittee on Labor - Health and Human Services - Education
House Committee on Appropriations

U.S. House of Representatives

May 6, 1986

Mr. Chairman, I appreciate the opportunity to submit this statement of support for the Impact Aid Program, which assists school districts in providing educational services to federally dependent children.

In each of the past several years, I have testified before this Subcommittee to support the Impact Aid Program, and in particular to support Impact Aid Category B. The Reagan Administration has consistently opposed continued funding for this valuable program. I am pleased that this Subcommittee and the Congress over the years have rejected the Administration's proposal. I join my colleagues in urging this Subcommittee once again to support funding for Impact Aid.

* * *

Two school districts in my Congressional District rely upon the Impact Aid Program: School Districts No. 2 and 17 in Sumter County, South Carolina. Both of these Districts are affected by the presence of Shaw Air Force Base, a major military facility. As in past years, the number of federally dependent children in these school districts has increased, while the level of reimbursement by the federal government has decreased.

In 1981, for example, School District No. 2 received approximately $1 million to educate approximately 2,000 federally dependent children. This year, the School District will receive only $466,000 to educate 2,133 children. In 1981, School District 17 received $175,399 to educate 1,355 federally dependent students, but this year the School District will receive only $23,500 for 1,510 students. These figures show dramatically that, despite rising educational costs, the federal government has been requiring school districts to accept and to educate a greater number of federally dependent children, but with far less money.

* * *

In 1950, Congress passed the Impact Aid Program to reimburse local school districts for the tax base loss caused by the presence of federal facilities. This program was enacted because the federal government accepted its responsibility to help local school districts educate federally dependent children. The program was created for reasons of equity and economy that are as valid today as when the program was first developed.

In South Carolina, as in other states, employers pay a substantial portion of local property taxes. In effect, employers assist in the education of their employees' children. Since the federal government pays neither property nor sales tax because of the presence of a federal facility, it avoids the financial responsibility shared by other employers. It is unfair to ask local school districts and other taxpayers to bear the costs incurred in educating children of parents whose employers make no contribution toward educational costs.

It is not only fair for the federal government to share in expenses caused by the location of a federal facility, but it is cost effective as well. As you know, the Military Construction Act of 1986 requires the transfer, no later than July 1990, of on-base schools to the appropriate school districts. This change was enacted because the Department of Defense recognized that it was cost effective to send federally dependent children to local school districts instead of paying for on-base schools.

The savings achieved by using public schools are impressive. For example, in 1982-83, the Department of Defense spent approximately $1,947 per pupil to educate dependent students at an Air Force base in Myrtle Beach, South Carolina, and approximately $2,640 per pupil at Fort Jackson, South Carolina. In contrast, the federal government spent approximately $500 per student under the Impact Aid Program in School District No. 2 in Sumter. Therefore, the federal government realized a savings of approximately $1,500 to $2,000 per student because of the Impact Act program.

At a time when students at on-base schools are being transferred to local school districts, it is inappropriate for the federal government to reduce Impact Aid reimbursements. The federal government should pay some form of compensation for the increased financial responsibility it is imposing on school districts.

The U.S. Senate appears to appreciate the importance of this program. The Senate recently approved a Fiscal Year 1987 budget resolution which provides for an increase of $76 million in Impact Aid funding above the current level of $663 million.

* * *

I also urge the Subcommittee to eliminate the Impact Aid categories of Super A and Super B. The cost of educating a Part A or B category student is the same whether these students comprise 18, 20 or even 40 percent of a particular school's population. If we cannot abolish the Super A and B categories, the Subcommittee should at least reduce the 100 percent reimbursement rate for Super As, and use the savings to increase funding for other Impact Aid recipients. Such a formula change, which I understand is also being considered in the Senate, would increase fairness and equity in the Impact Aid program.

It is irresponsible for the federal goverment to shift its education costs to local governments. Local school districts have limited resources, and they cannot sustain continued reductions in their budgets without eventually seeking to recover lost revenue. If the federal government reduces further its contribution toward educating federally dependent children, local taxes may have to be raised substantially. It would be unfortunate if school districts were also compelled to charge tuition, exclude or bus students, or adjust school district boundaries in order to compensate for the loss of Impact Aid funding.

* * *

Mr. Chairman, I commend you and the members of this Subcommittee for your review of the Impact Aid Program. I am confident that the Subcommittee will conclude that the reasons which compelled the creation of this program are still as valid today as thirty years ago. I hope the Subcommittee will approve legislation to continue federal funding for the Impact Aid Program at a sufficient level and according to an equitable formula that will uphold the federal government's obligations to dependents of federal personnel.

TESTIMONY OF CONGRESSMAN JIM BATES ON IMPACT AID

My San Diego county district is home port to one-fourth of United States' Navy ships, the site of the most heavily used naval airbases, and the center of United States Marine Corps training. The federal government in the largest landholder and employer in my county. The national interest requires that important large defense installations be located in San Diego's harbor.

San Diego continues to be an impacted community. San Diego has nearly 24,000 students from families of federal employees this year attending schools in the San Diego Unified School District, a third of those from families who also live on federal property. Since 1986, the schools educating these students have been severely hurt by reductions in the Impact Aid program.

During 1979-1980, San Diego received almost $15 million in impact aid funding. This constituted 6% of the school district's budget, a relatively small figure in comparison to the high percentage of federally connected school children. This year, after the first year Gramm-Rudman-Hollings reductions, the total income estimate for all categories of impact aid has dropped $4,221,509 -- sizable reduction. The losses were not replaced with state funding. As a result, the school district had to reduce expenditures and programs by over $50 million from 1980 to 1986. The $50 million loss caused the school district to reduce many of the programs that served all students. They, however, fell most heavily on those programs that provided extra assistamce to those students with the greatest needs. Also reduced were other programs that supported the basic instructional program. The school district's own compensatory education program that supplemented federal and state programs was eliminated, and reductions were made in maintenance and other programs that provide support to the overall district program. Despite some assistance from the state, the district has never been able to replace these tremendous reductions. Additional burdens created by the federal government during this period have intensified the problems faced by the San Diego school system. The school district's enrollment is now over 7% Indochinese refugee children who have serious educational needs.

Impact aid has never been a bonanza to the school district. The federal government has always been a major factor in the community. Funding for the Impact Aid program, however, has never exceeded 6% of the school district's budget. By last year the percentage of federal funding for the program had declined to 1% of the district's school budget. The school district has no means of replacing this lost income. Impact Aid is the only method by which the government grants some limited equity to the local community that provides free public education to the children of federal employees.

TESTIMONY OF WM. L. DICKINSON
BEFORE HOUSE APPROPRIATIONS SUBCOMMITTEE
ON LABOR, HEALTH & HUMAN SERVICES
MAY 6, 1986

MR. CHAIRMAN:

THANK YOU FOR ALLOWING ME THE OPPORTUNITY TO TESTIFY BEFORE YOUR SUBCOMMITTEE TODAY IN BEHALF OF THE IMPACT AID PROGRAM FOR FISCAL YEAR 1987.

AS YOU ARE WELL AWARE, THE GOVERNMENT COMPENSATES SCHOOL SYSTEMS WHOSE ENROLLMENTS AND AVAILABLE REVENUES ARE DEEMED TO HAVE BEEN ADVERSELY AFFECTED BY FEDERAL ACTIVITIES. IN MY DISTRICT, THE SECOND DISTRICT OF ALABAMA, TWO MAJOR MILITARY INSTALLATIONS HAVE A TREMENDOUS IMPACT ON THE STATE AND LOCAL REVENUES FROM THESE AREAS.

THE IMPACT AID PROGRAM IS DIVIDED INTO TWO CATEGORIES. CATEGORY "A" STUDENTS ARE THOSE CHILDREN WHO BOTH LIVE ON AND WHOSE PARENTS WORK ON FEDERAL PROPERTY. CATEGORY "B" STUDENTS ARE THOSE CHILDREN WHO EITHER LIVE ON, OR WHOSE PARENTS WORK ON FEDERAL PROPERTY.

FOR FISCAL YEAR 1987, THE ADMINISTRATION'S BUDGET REQUEST HAS SLATED IMPACT AID FUNDING FOR $548 MILLION, ALL OF WHICH IS TARGETTED FOR "A" CATEGORY STUDENTS, WITH NO FUNDING FOR "B" CATEGORY STUDENTS. THE ADMINISTRATION'S RATIONALE IS THAT "B" STUDENTS IMPOSE LITTLE OR NO BURDEN ON MOST SCHOOL SYSTEMS. THIS COULDN'T BE FURTHER FROM THE TRUTH IN THE SECOND DISTRICT OF ALABAMA, AS IN 1985, 78% OF ALL IMPACT AID FOR ALABAMA WAS TARGETTED FOR "B" CATEGORY STUDENTS.

THE MAJOR FEDERAL PROPERTIES IN MY DISTRICT ARE MAXWELL/GUNTER AIR FORCE BASE AND FORT RUCKER, WHICH ARE ASSOCIATED WITH FOUR SCHOOL SYSTEMS IN PARTICULAR; THEY ARE: DALEVILLE CITY, ENTERPRISE CITY, MONTGOMERY COUNTY AND OZARK CITY SCHOOLS.

FOR 1985, IMPACT AID FUNDING FOR THESE SCHOOL SYSTEMS WAS AS FOLLOWS:

DALEVILLE CITY, OUT OF $125,061 - $86,607 OR 69% WENT FOR "B" STUDENTS

ENTERPRISE CITY, OUT OF $348,067 - $318,893 OR 91% WENT FOR "B" STUDENTS

MONTGOMERY COUNTY, OUT OF $1,110,000 - $891,000 OR 80% WENT FOR "B" STUDENTS

OZARK CITY, OUT OF $304,000 - $182,000 OR 59% WENT FOR "B" STUDENTS

AS YOU CAN SEE MR. CHAIRMAN, "B" CATEGORY STUDENTS MAKE UP A LARGE MAJORITY OF TOTAL IMPACT AID FUNDING TO THESE SCHOOL SYSTEMS IN MY DISTRICT, AND WOULD BE DEVASTATING TO THESE SCHOOLS IF "B" CATEGORY STUDENTS ARE NOT FUNDED FOR FISCAL YEAR 1987.

AGAIN, I WOULD LIKE TO EMPHASIZE MY SUPPORT AND ENCOURAGE THE CONTINUATION OF FUNDING FOR FEDERALLY CONNECTED STUDENTS, WHICH WILL GUARANTEE QUALITY EDUCATION FOR THESE CHILDREN IN IMPACTED AREAS.

THANK YOU FOR THIS OPPORTUNITY TO SPEAK BEFORE YOUR SUBCOMMITTTEE.

STATEMENT OF CONGRESSMAN TOM DASCHLE
BEFORE
THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

TUESDAY, MAY 6, 1986

Mr. Chairman, I would like to thank you for holding this hearing on funding for Impact Aid, a program which is tremendously important to my home state of South Dakota. I appreciate the opportunity to present to the Subcommittee today my support for Impact Aid.

Impact Aid plays a critical role for 42 school districts in South Dakota. They receive approximately $19 million annually in lieu of taxes for the educational services rendered to Federally connected youngsters. In recent years the program has endured at least its share, if not more, of budget cuts, yet Impact Aid districts in South Dakota and across the country have managed to continue providing quality education for their students.

I regard the proposed cuts for Impact Aid in the President's Fiscal Year 1987 Budget as potentially disastrous. These reductions in funding compound the effect of previous cuts and jeopardize not only the quality of services but also the schools and programs themselves. We cannot cut off these school districts and thereby run the risk of impairing our children's opportunities for growth and achievement.

Impact Aid plays a particularly important role in South Dakota on military installations and on Indian reservations. While federal pursestrings are tight for many Indian programs, the need for education on the reservation remains great and Impact Aid is the lifeline for schools on the Indian reservations. Also, our nation is experiencing a dramatic military buildup which, in turn, increases the number of students attending schools on our military bases. These factors contribute to the real need for a constant, reliable source of funding for Impact Aid districts.

In his fiscal year 1987 budget, the President has, among other recommendations, proposed eliminating one category of Impact Aid "B" students; that is, students whose parents either live on or work on Federal property. This proposal which would be very detrimental to South Dakota as there are over 3,000 such students in the state. The President's elimination of $130 million in category "B" funding would result in the exclusion of over one million Impact Aid "B" children nationwide. I urge my colleagues to reinstate funding for Category "B".

Even more devastating is the $5 million proposed for P.L. 81-815, School Construction, which is not enough to build even one school building in one school district in South Dakota, or any other state, for that matter. Considering the many, many new school buildings and facilities that are needed across the nation, this paltry sum is unacceptable. The recommended $5 million is not even enough to complete the construction projects which were begun just last year.

For the above reasons, I urge the House Appropriations Subcommittee on Labor-Health and Human Services-Education to consider carefully their budget recommendations and to include an adequate level of funding for Impact Aid. As a nation and as a government, we have a commitment to the Impact Aid districts and an obligation we must honor in providing support for their programs and their students.

Thank you.

Sherwood Boehlert

TESTIMONY OF
REP. SHERWOOD BOEHLERT (R-NY)
before the
LABOR-HHS-EDUCATION APPROPRIATIONS SUBCOMMITTEE
May 6, 1986

Mr. Chairman, I greatly appreciate the opportunity to present my testimony on the subject of Impact Aid. Simply put, the impact aid program is not a federal handout, but a federal obligation, and should be treated fairly in the appropriations process.

I firmly believe that to balance the nation's books, we must continue to look for ways to cut government spending. But we shouldn't be victims of a "budget-cutting-at-all-costs" mentality. Some programs actually represent a legitimate government obligation, and they make good, cost-effective sense for the people of this country. Impact Aid is one of those programs.

Impact Aid represents a federal obligation to compensate school districts that lose revenue because the federal government has taken property off the tax rolls, or provided various tax preferences for federal personnel in the area. It is unreasonable for the federal government to impose itself upon a local jurisdiction without helping to pay for the costs it brings. Without Impact Aid, the local taxpayers, many of whom are senior citizens on fixed incomes, must pay a heavier burden of taxes to support public education. That is unacceptable.

Griffiss Air Force Base, in the City of Rome, NY, is responsible for the air defense of the entire Northeastern United States. Rome Air

Development Center is the Air Force's largest laboratory. Because of these federal installations, there are 2,600 children in the Rome City School District whose parents pay significantly less in local taxes than many of their neighbors in the community.

If Impact Aid were cut off, or drastically reduced again, then either the public schools would be crippled in their ability to provide a decent education to our kids, or the local taxpayers would have to subsidize their neighbors to an even greater extent. The only other alternative, putting these federally-connected children in "federal" schools--military base schools--is also expensive to taxpayers. In that respect, Impact Aid is a very cost-effective program.

In any case, even as we are cutting government spending, we must not forget our responsibilities. Our local families cannot refuse to pay their bills just because they come up a little short at the end of the month--and neither can we. Mr. Chairman, I strongly urge you and your colleagues on this subcommittee to remember the merits of the Impact Aid program, and treat it fairly in the appropriations process.

Mr. Chairman, I would also like to ask permission to insert in the record a letter I have received from Mr. Paul R. Doyle, who is the Superintendant of Schools for the Rome City School District. Mr. Doyle's letter will provide further facts and figures on how Impact Aid is used in his school district.

Thank you.

ROME CITY SCHOOL DISTRICT

112 EAST THOMAS STREET
ROME, NEW YORK 13440

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Instruction/Personnel
Telephone (315) 339-0371

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March 12, 1986

The Honorable Pete V. Domenici, Chairman
Committee on the Budget
SD-621 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Domenici:

The Rome City School District recognizes the tremendous burden placed upon our national economy by the recent budget deficits and the accumulated national debt. This district stands ready to assume its fair share of cuts in federal grant programs. Emphasis is placed on the word "fair" in that the district trusts that educational programs will not receive a disproportionate share of the required cuts. The word "grant" is emphasized to indicate that this district recognizes the necessity for reduction of grant programs by freezing them at prior year levels or effecting actual reductions in the level of support. This district participates in a sizeable grant program under ESEA Chapter I, which, it is assumed, will sustain cuts as a grant program.

However, the Rome City School District emphatically asserts that the PL81-874 program, Impact Aid, is not a grant program and therefore should not be subject to cuts. For more than 150 years the federal government has provided funds for the education of dependents of military personnel stationed within the United States. The Rome City School District is currently educating approximately 2,600 students who are eligible for Impact Aid due mainly to the existence of Griffiss Air Force Base within its district boundaries. Almost 900 students live in base housing, which is totally tax exempt, and therefore contributes nothing to the local property tax levy, which is the major souce of local support for educational costs.

A study of the district's current budget indicates a per pupil cost for educating its 8,107 students of $4,099 each. The per pupil revenue of the district, from all sources other than local property tax levy and federal aid under PL-874, is $2,645. This leaves a difference between the two stated figures of $1,454, which should be regarded by the federal government as an obligation for services rendered. However, for each "A" student the district receives only $867, which is 33% of the New York State local contribution rate, which last year was $2,627. Deducting the $867 from $1,454 leaves a shortfall of $587 which must be assumed by the local property taxpayer to pay for the educational program of each military "A" student. This means that local taxpayers are already supporting military "A" students' educational costs at over $525,000 cost per year to them. This is not a case of local taxpayers making up for reductions in grant programs. Rather, it is an instance of local taxpayers subsidizing the education of students living on a military installation within the school district boundaries.

The Impact Aid Program has, during the last ten years, suffered major reductions and is now operating at about 50% of its original level of entitlement. While it is generally accepted that the current deficit situation requires cuts in many grant programs, it is an injustice for the federal government to pay any less than its full share of legitimate bills for services rendered.

Justification for aid to "B" students has become controversial in recent years. This controversy stems not from the question of validity of aiding "B" students' educational cost, but rather from a lack of information or understanding of the basic premises upon which "B" student aid is based. The finding of the Commission on the Review of the Federal Impact Aid Program, completed in 1980, was that "the basic premises of the program have validity today and will continue to have that validity until there is a major change in structure of financing public education." More recently the National Association of Federally Impacted Schools, headquartered in Washington, D.C., completed a study of the effect of "B" students on a school district. It illustrates each of the several types of "B" students who create a burden on the district, and presents facts which support the continuation of "B" student aid. The fact that aid to "B" students is significantly less than that for "A" students should not be overlooked. In the Rome City School District, which is a Super "B" district having more than 20% of its school population classified as "B" students, the average "B" pupil aid is approximately $250, which is a minor part of the $4,099 per pupil cost. If this district were a regular "B" district, the average "B" student aid would be about $42 per student. However, due to the large numbers of "B" students in many districts, a loss of "B" aid would constitute a significant loss to those districts. Furthermore, just as with "A" students, this aid represents a legitimate payment for services rendered where sizeable and unjust reductions have already occurred, and it would be grossly unfair to make further reductions in aid to "B" students.

With the above facts in mind this district urges you to look closely at grant programs and apply any cuts in programs equitably. It more strongly urges, however, that you recognize that impact aid is not a grant program and that it has already suffered unjust cuts. Your support of continued aid for "A" and "B" students, now and in the future, would be greatly appreciated. This is a just cause and your support can prevent further injustices to the "A" and "B" students educated under the Impact Aid Program. Thank you very much.

Very truly yours,

Paul R. Doyle
Superintendent of Schools

PRD/ta

cc: Congressman Sherwood Boehlert
Congressman Frank Horton
Senator Alfonse M. D'Amato
Senator Daniel Patrick Moynihan
Mr. Thomas Shipley, Ed.D., Executive Director
National Association of Federally Impacted Schools

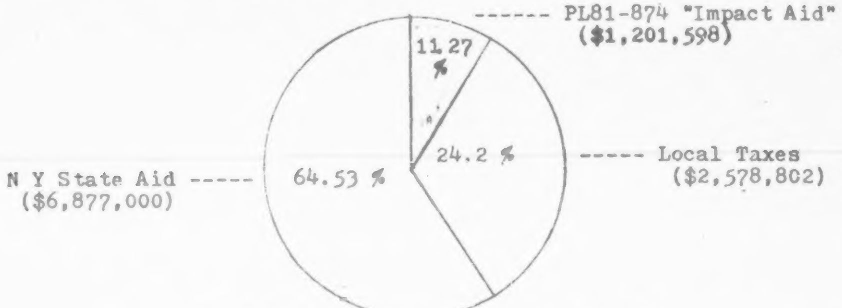
FACT SHEET ON PL81-874 FEDERAL "IMPACT AID"

ROME CITY SCHOOL DISTRICT
Rome, New York 13440

Current Cost of Educating 2,600 Federally Connected Students Associated With Griffiss Air Force Base, Rome, New York:

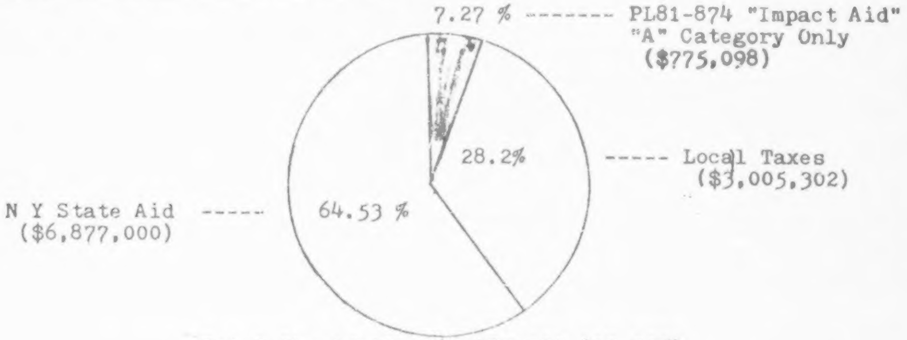
$10,657,400 per year

Current Revenue from All Sources:



Total Shortfall: $9,455,802 (88.73%)

Revenue Should "B" Category Aid Be Lost:



Total Shortfall: $9,882,302 (92.73%)

(It is easy to see from the above that the Federal Government IS NOT MEETING ITS' OBLIGATION TO ADEQUATELY COMPENSATE THE ROME PUBLIC SCHOOLS for educating 2,600 FEDERALLY CONNECTED STUDENTS!!!!)

FURTHER REDUCTION OF PL81-874 ENTITLEMENT FUNDS (NOT A GRANT) WILL FORCE ADDITIONAL TAX BURDEN ON LOCAL TAXPAYERS WHO ALREADY PAY MORE THAN TWICE AS MUCH AS THE FEDERAL GOVERNMENT TO EDUCATE THESE 2,600 FEDERALLY CONNECTED STUDENTS! PLEASE HELP TO KEEP THIS ENTITLEMENT PROGRAM INTACT.

WEDNESDAY, MAY 7, 1986.

COLLEGE HOUSING LOANS

WITNESSES

FATHER WILLIAM L. GEORGE, GEORGETOWN UNIVERSITY
FATHER HAROLD BRADLEY, GEORGETOWN UNIVERSITY
FATHER T. BYRON COLLINS, GEORGETOWN UNIVERSITY

Mr. NATCHER. Our first witnesses this morning are Father Collins, Father George and Father Bradley. It is a pleasure to have you before the committee. You may proceed in the order that you desire.

Reverend GEORGE. I am Father William George, and I will be going first.

We are assistants to the President of Georgetown, and I thank you for permitting us to testify. I would like to ask the committee to continue the college housing revolving funds at the same levels of last year.

The Administration is asked to sell $600 worth of the notes to the public, and if that occurs, I ask the colleges and universities be given the first option at a rate as good or better than they would offer to the public.

In 1985, the program loaned $30,000,000 for college housing, and the total project costs were $160,000,000, so the Federal dollars contributed had a lot of private capital added to it.

Even if the sale is made, there would be enough funds left in the college housing revolving loan fund to operate at the same level as last year.

Thank you, Mr. Chairman.

Mr. NATCHER. Father Collins.

Reverend COLLINS. Mr. Chairman, Mr. Conte, Mr. Early, Mr. Hoyer, I will be very brief. Two topics: One, bioethics, we ask the committee's continued support of that. That is a national service line that Georgetown over the years has competitively been awarded.

We ask the committee's continued interest in this.

The second and major point is the HEAL program. This is a loan program to students of the health professions. The request on the part of the budget is to limit the authority which—asking this committee to limit the amount of loans, we ask that the amount be at the authorized amount.

This is a loan program where it is a last resort loan program, no cost, presently no cost to the Federal Government.

The student borrows the money commercially. There is a provision for insurance in the amount of money, and it is an excellent program so far. However, for over at least a year I testified asking that the regulations on it be issued.

The year before I asked. The regulations on it have not been issued. The changes that were put in the authorized law to make this a good program, the regulations hadn't been issued, so my appeal to the committee is to urge the Secretary of HHS please put the regulations out, so this can be a self-sufficient loan program.

It is interesting to note, the largest users of the program are the States of California and Massachusetts.

Thank you, Mr. Chairman.

Mr. **Natcher**. Thank you, Father Collins.

Father Bradley.

Reverend **Bradley**. Mr. Chairman, I am here to ask that the committee continue to support the Georgetown University Center for Immigration Policy and Refugee Assistance Program and National Leadership Training.

The purpose is to identify problems shared by administrators of refugee resettlement and assistance programs at the Federal, State and community levels, to bring together the administrators of these programs so their problems can be addressed in a cooperative and coordinated way, and to provide leadership training and technical assistance to those whose refugees are integrated into our society.

This program is for State and local officers where information and ideas are to be exchanged and solutions for problems currently confronting administrators and legislators can be sought.

Thank you, Mr. Chairman.

Mr. **Natcher**. Thank you, Father Bradley. We want to thank you all for appearing before the committee at this time. Every consideration will be given to your requests, gentlemen.

[The statements follow:]

STATEMENT OF

REV. HAROLD BRADLEY, S.J.

AND

REV. WILLIAM GEORGE, S.J.

SPECIAL ASSISTANTS TO THE PRESIDENT OF GEORGETOWN UNIVERSITY

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

May 7, 1986

11:00 A. M.

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

May 7, 1986

During calendar year 1985, Georgetown University's Center for Immigration Policy and Refugee Assistance (CIPRA) completed the first phase of the National Leadership Training Program (NLTP) which was funded by an initial grant of $75,000 from the Office of Refugee Resettlement of the Department of Health and Human Resources. The purpose of the program is to identify problems shared by administrators of the refugee resettlement and assistance program at the federal, state, and community levels; to bring together the administrators of the program so that these problems can be addressed in a cooperative and coordinated way; and to provide leadership training and technical assistance to those through whose efforts refugees are integrated into American society.

Three regional training sessions were followed by a three-day training session in November, the theme of which was "Refugees, Programs, Communities: Paths to Autonomy." Sessions were devoted to improving leadership skills required by key state and private agency personnel to manage people and programs effectively. Areas of concentration were employment programs, ESL/language training, case management systems, development of mutual assistance associations; crisis management planning; and resource development. Attendees included state refugee coordinators and other state officials; representatives of mutual assistance associations and voluntary agencies and representatives of the Office of Refugee Resettlement.

Not only is there a continuing need for training in leadership and technical skills at the state coordinator level, there is a parallel need for concentrated efforts within the most severely impacted areas, for example, California and Oregon. CIPRA has earlier testified about the desirability of scheduling regional seminars for elected and appointed state and local officials where information and ideas could be exchanged, and solutions for problems currently confronting administrators and legislators can be sought. Such seminars should include representatives of mutual assistance associations and service providers as well. We estimate that funding of $100,000 will be needed to schedule five such regional seminars.

We have attached to this testimony a letter to the Secretary of the Department of Health and Human Services from the Honorable Peter W. Rodino, Jr., Chairman, and the Honorable Hamilton Fish, Jr., Ranking Minority Member of the House Committee on the Judiciary supporting our proposal.

NINETY-NINTH CONGRESS

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U.S. House of Representatives
Committee on the Judiciary
Washington, DC 20515
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GENERAL COUNSEL
M. ELAINE MIELKE
STAFF DIRECTOR
GARNER J. CLINE
ASSOCIATE COUNSEL
ALAN F. COFFEY, JR.

September 26, 1985

Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

This is to advise you of our deep interest in the National Leadership Training Conferences that have been held over the past year by Georgetown University.

Based on the materials produced as a result of these meetings and the views expressed by many of the participants, it is evident that these training conferences have been a successful undertaking. Certainly, the exchange of views and experiences by the participants, especially the State Refugee Coordinators, has served to identify shared problems in the resettlement program and to develop effective ways to address them.

For this reason, we would urge that Georgetown University's contract be extended and sufficiently funded. In testimony presented to Congress, the cost of additional conferences to be scheduled for the next year was estimated at $100,000. In fact, it is our view that Georgetown could play a key role in the initial implementation of the so-called "Fish Amendment" by the states of California and Oregon.

Based upon the network among the various resettlement actors established by Georgetown in the conduct of its leadership training conferences, we believe the University could be instrumental in arranging a series of meetings between county officials, mutual assistance associations, service providers, voluntary agency officials and State officials in both California and Oregon.

In summary, we strongly believe that Georgetown University can play a critical role by providing the technical assistance and leadership training essential to facilitating the effective and efficient implementation of the legislative initiative created by the Fish Amendment.

Sincerely,

PETER W. RODINO, JR.
Chairman

HAMILTON FISH, JR.
Ranking Minority Member

PR:HF:tbw

cc.: - Hon. Silvio O. Conte

DR. SAMUEL HARVEY, JR.
ASSISTANT TO THE PRESIDENT FOR
URBAN AFFAIRS AND FEDERAL RELATIONS
GEORGETOWN UNIVERSITY

MRS. MARY ALBERT
COORDINATOR OF AFFILIATED PROGRAMS AND
INTERGOVERNMENTAL RELATIONS
GEORGETOWN UNIVERSITY

REV. WILLIAM L. GEORGE, S.J.
ASSISTANT TO THE PRESIDENT OF
GEORGETOWN UNIVERSITY

HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH
AND HUMAN SERVICES, AND EDUCATION

May 7, 1986

TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

May 7, 1986

Mr. Chairman, Members of the Subcommittee:

I am Reverend T. Byron Collins, S.J., Special Assistant to the President of Georgetown University. With me is Mary S. Albert, Special Assistant to the Chancellor, Georgetown University Medical Center.

We appreciate the opportunity to appear before you today to urge rejection of the Administration's proposed deletion of funding for the health professions, especially advanced nurse education.

For several years, we have appeared before you each Spring to underscore the necessity for Federal funding of nursing programs. With the dramatic changes in health care delivery and nursing practice, the over one million registered nurses in the U.S. have responsibilities that have changed dramatically from a few years ago. Advanced nursing education programs permit the building of the cadre of nurse leaders so important to meet today's changing practice.

At Georgetown, we have a thriving graduate program with specialties in gerontology, nurse-midwifery, and administration. Federal funding has enabled us to develop curricula and provide traineeship support for students of modest background.

As we seek more cost-effective ways to use health personnel, we find that there is no question that nurses with advanced education can "extend" the physician and other professionals in the health care team, and offer more care for less resources. Advanced nurse education becomes a truly cost-effective investment and we urge its restoration in the budget.

Thank you for this opportunity to testify before you.

TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION
May 7, 1986

Mr. Chairman, and Members of the Subcommittee:

I am Reverend T. Byron Collins, S.J., Special Assistant to the President of Georgetown University. With me is Mary S. Albert, Special Assistant to the Chancellor of the Medical Center. We are here today to urge your rejection of the President's request in the Fiscal Year 1987 budget to cap the Health Education Assistance Loan (HEAL) loans at $100 million dollars.

There are no Federal outlays or obligations for the HEAL program. HEAL loans, guaranteed by the Federal government, are made to health professions students by private lenders. Interest is not subsidized by the Federal government. Student borrowers pay the full interest based on the 90 day T-Bill + 3%. Student borrowers also pay for all defaults from an insurance fund established for this purpose to which students pay a certain percentage "upfront".

Mr. Chairman, this loan program, which requires no appropriations, is essential at the fully authorized amount of $290 million for Fiscal Year 1987 so that students from modest family backgrounds may enter the health professions.

We urge the following, with respect to HEAL:

1) Administration interest in limiting Federal guarantee to 80%, and requiring 20% risk-sharing by the lenders should not apply to HEAL. HEAL has a separate insurance fund to pay for all defaults, and Federal funds are not at risk. Unlike other Federal loans, there is no Federal capital committed to the program.

2) The credit authority should be granted at the beginning of the Fiscal Year, so that lenders and borrowers can plan for the entire year. Credit authority for HEAL loans presently is released periodically throughout the year. Students, schools and lenders need to plan for the entire academic year.

3) The Department of Health and Human Services should issue at once the new HEAL regulations which have been years in the drafting. Each year for several years, we have come before you to urge that the risk of HEAL delinquency could be greatly reduced by stricter requirements imposed on borrower, school, and lender (such as need analysis by the school, and more stringent due diligence by the lender). We are convinced that health professionals with HEAL loans prosper sufficiently to repay their

loans, and they should be given no quarter if they fail to do so. However, the regulations must put the stricter requirements into effect, and they are long overdue.

4) Finally, and most important, HEAL loans must not be capped at $100 million. The demand for the HEAL loan, paid fully by the borrowers, will reach the $290 million authorized for Fiscal Year 1987; $285 million in loans have already been issued in the present fiscal year. Without sufficient HEAL loans, Georgetown and other schools risk becoming elitist, enrolling only the wealthiest students. With HEAL, students can finance their way through school and repay educational costs through future earnings.

Mr. Chairman, we thank you very much for the opportunity to testify before you.

APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

Mr. Chairman and members of the Committee, I am Father T. Byron Collins, S.J., Assistant to the President of Georgetown University. I am accompanied by Dr. Samuel Harvey, Jr., who is also an assistant to the President of Georgetown University. We would like to thank the Committee for its support of the Bioethics Library and Information System in FY 1986 through the National Library of Medicine.

Two unique information services have been established at the Kennedy Institute of Ethics at Georgetown University: the National Reference Center for Bioethics Literature (NRC) and the Bioethics Information Retrieval System.

The Congress has recently acknowledged the importance of the field of bioethics by establishing a Biomedical Ethics Board from its own membership and an Advisory Committee. The National Reference Center for Bioethics Literature and the Bioethics Retrieval System will be essential resources for this newly established Congressional body.

The Ethics Library, founded in 1973, was competitively awarded in FY 1985 a $1.4 million grant by the National Library of Medicine for the NRC's development as an extension of the Ethics Library. Commencing with the receipt of this award, the NRC has embarked on a program to actively disseminate bioethics information throughout the nation for consultation on such topics as Baby Fae, Diagnostic Related Groups, and the Living Will. A database of international organizations on bioethics, which will form the basis for a network of bioethics libraries throughout the world, is now being developed by the NRC staff.

The Bioethics Information Retrieval Service was similarly established following a competitive, peer review process, and since 1974 has been continuously supported by the NLM as a comprehensive, cross-disciplinary information service to monitor the scattered literature on bioethical issues. This service has been made available for use by health professionals, policymakers, researchers, teachers and students, clergy and others with interest in the increasingly important and complex value dilemmas that we confront in the areas of health care and biomedical research. The primary instruments of supplying this information are the BIOETHICSLINE database, a function of the Bioethics Information Retrieval System, and the Bibliography of Bioethics, the information indexed in both having been collected by the NRC.

In 1985, nearly 2,000 persons used the resources of the NRC in person and over 800 BIOETHICSLINE searches were performed in response to other queries, demonstrating a 36% increase between 1983 and 1985 in the use of BIOETHICSLINE. Thus it can be clearly recognized that an ever growing number of users will benefit in the future from the important information resources it produces in a field of increasing public concern.

The request of federal funds for operating these two national and international resources will be $725,000 during federal FY 1987. In addition, Georgetown University provides over a million dollars from its resources for the Bioethics Center, which hosts these two efforts. We would like to request the Committee to indicate its continued support for this unique national service program.

On behalf of our President, Rev. Timothy S. Healy, S.J., we thank you and the Committee for this opportunity to testify.

NATIONAL LIBRARY of MEDICINE

FACT SHEET

Bethesda, Maryland SEPTEMBER 1985

BIOETHICSLINE

What BIOETHICSLINE Contains

BIOETHICSLINE (short name BIOETHICS) is a National Library of Medicine (NLM) online bibliographic database focused on questions of ethics and public policy in the fields of health care and biomedical research. Produced by the Bioethics Information Retrieval Project of the Kennedy Institute of Ethics at Georgetown University, BIOETHICSLINE includes citations on such topics as euthanasia, organ donation and transplantation, the allocation of health care resources, patients' rights, codes of professional ethics, in vitro fertilization and other reproductive technologies, genetic intervention, abortion, behavior control and mental health therapies, and human experimentation. Because bioethics is a cross-disciplinary field, the scope of BIOETHICSLINE spans the literatures of the health sciences, law, philosophy, religion, the social sciences, and the popular media.

BIOETHICSLINE currently contains approximately 19,000 citations to English-language materials dating from 1973 to the present. It incorporates nine document types: journal articles, monographs, analytics (chapters in monographs), newspaper articles, court decisions, bills, laws, audiovisual materials, and unpublished documents. The database is updated bimonthly, with 1,800 to 2,000 records being added each year. Since 1982, approximately 20% of the citations added include short abstracts written by the Bioethics Information Retrieval Project Staff.

How BIOETHICSLINE Is Searched

To enter the BIOETHICSLINE file, login as usual to NLM's ELHILL retrieval system and enter the command FILE BIOETHICS after a USER: cue.

BIOETHICSLINE is best searched using Keywords, which consist of subject terms drawn from the controlled vocabulary of the *Bioethics Thesaurus* and proper nouns (such as the names of persons, places, organizations, and court decisions). The *Bioethics Thesaurus* is currently available for $5 from the Bioethics Information Retrieval Project; it is also included in every annual volume of the *Bibliography of Bioethics*, the print version of BIOETHICSLINE.

Approximately 80% of the *Bioethics Thesaurus* Keywords are mapped to terms in NLM's *MeSH (Medical Subject Headings)* vocabulary, making it possible to search BIOETHICSLINE using *MeSH*. Text word searching is also possible in BIOETHICSLINE, with text words being derived from the Abstract, Corporate Author, General Note, Keywords, Publisher and Title fields.

Other data elements that may be searched directly include Author, Date of Publication, Entry Month, ISBN and ISSN, Publication Type, and Title of Journal. A special data element, Subject Captions, permits quick current awareness retrieval by broad subject area (e.g., genetics and reproduction, health care delivery) or by type of approach (clinical, legal, philosophical, popular, or religious) to the study of bioethical issues.

Search terms may be entered singly or combined by means of the Boolean operators AND, OR and AND NOT. Some data elements require the use of an element qualifier; for example, Keywords must be searched with the qualifier (KW). Records may be printed online at the user's terminal, or offline and mailed to the user from NLM.

Reference materials on how to search BIOETHICSLINE include NLM's *Online Services Reference Manual*, the *Bioethics Thesaurus* developed at the Kennedy Institute of Ethics, a 1984 article on the database (Tamar Joy Kahn and Cecily Orr, "BIOETHICSLINE: An Overview for Searchers," *Medical Reference Services Quarterly* 1984 Fall 3(3):1-21) and occasional articles in the *NLM Technical Bulletin*.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • National Institutes of Health

Where BIOETHICSLINE Is Available

BIOETHICSLINE is one of the databases comprising NLM's Medical Literature Analysis and Retrieval System (MEDLARS). It can be accessed from any of approximately 3,000 NLM Online Centers in hospitals, medical schools, universities, government agencies, and commercial firms throughout the United States and in several other countries. Information on the Online Center closest to you, or on how your institution can become an Online Center, can be obtained from the Regional Medical Library in your area of the country (see list at the end of this Fact Sheet) or from the MEDLARS Management Section of the National Library of Medicine.

When BIOETHICSLINE Is Available

BIOETHICSLINE is available online 24 hours a day, 7 days a week, except from 11:00 p.m. to 11:15 p.m. (Eastern time).

What BIOETHICSLINE Costs

The cost of searching BIOETHICSLINE is calculated from a pricing algorithm developed by NLM. An hour of "prime" computer connect time between 10:00 a.m. and 5:00 p.m. (Eastern time) averages about $22. At all other times, an hour of connect time usually costs about $15. NLM also charges 18¢ for each page of citations printed offline.

How to Get More Information on BIOETHICSLINE

Contact the Bioethics Information Retrieval Project at the Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057, phone (202) 625-2383, for help in formulating BIOETHICSLINE search strategies, and for information about ordering the *Bioethics Thesaurus* or the *Bibliography of Bioethics*. The Bioethics Library at the Kennedy Institute of Ethics (same address and phone) will provide assistance in locating difficult-to-find publications cited in BIOETHICSLINE.

For further information on the NLM literature retrieval system, the Online Centers which access it, or the costs of searching BIOETHICSLINE, contact the Regional Medical Library which serves your state or the MEDLARS Management Section, National Library of Medicine, Bethesda, Maryland 20894, phone (301) 496-6193.

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4. MIDCONTINENTAL REGIONAL MEDICAL LIBRARY PROGRAM
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5. SOUTH CENTRAL REGIONAL MEDICAL LIBRARY PROGRAM
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Health Science Center at Dallas
5323 Harry Hines Blvd.
Dallas, Texas 75235
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TWX: 910-861-4946

6. PACIFIC NORTHWEST REGIONAL HEALTH SCIENCES LIBRARY SERVICE
Health Sciences Library
University of Washington
Seattle, Washington 98195
Phone: 206-543-8262
States served: AK, ID, MT, OR, WA
TWX: 910-444-1365

7. PACIFIC SOUTHWEST REGIONAL MEDICAL LIBRARY SERVICE
UCLA Biomedical Library
Center for Health Sciences
Los Angeles, California 90024
Phone: 213-825-1200
States served: AZ, CA, HI, NV
TWX: 910-342-6897

HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

Mr. Chairman and Members of the Committee, I am Father William L. George, S.J., Assistant to the President of Georgetown University. Thank you for the opportunity to testify on a matter of great importance to Higher Education.

I would like to urge the Committee to resist the Administration's proposal to sell the College Housing Loan portfolio. Likewise, I would urge the committee to release funds for additional loans as authorized in the House and Senate Education Bills.

The House Education Act (H.R. 3700) reauthorizies the College Housing Loan program, allowing for the renovation of academic facilities. These funds would be available at a 5.5% long-term rate. There are numerous compelling reasons to support this update to the College Housing Loan program. Today I would like to mention just three.

First, selling the College Housing Loan portfolio will cheat the Government out of the real value of these assets. This program requires no budget authority and no direct appropriations; new loans are made with funds from payment from previous loans. A portfolio of 3% loans payable over thirty years is not an attractive investment. The portfolio will only be sold at a tremendous discount -- probably less than half of the total outstanding loan value of $2.3 billion. As a result, no new loans will be made in the future because repayment income from existing loans would belong to the purchaser of the portfolio. By selling the portfolio, the Government would be trading slim current earnings for tremendous long-term benefits to the needs of higher education.

Secondly, there is a tremendous need for money for academic facilities renovation. Over 50% of higher educations physical plant was built before 1960. In recent decades decreasing federal assistance for student aid has shifted that financial responsibility increasingly to education institutions. In addition, the demands of inflation, energy costs, and staff salaries have resulted in the deferral of the upkeep and repair of academic facilities. Current estimates for the cost of facilities and equipment renewal and replacement for all of higher education range up to $50 billion.

Without Federal participation in financing academic facility renovation, it is often difficult or impossible for schools to find loans for academic facilities that depend on tuition charges. While dorms have direct expected revenue from rent and can be used even if the loan is in default, a classroom has very little attraction as collateral for a bank. Our country's excellent higher education systems relies on having physical facilities conducive to intellectual and academic endeavor.

Thirdly, Federal loans in the College Housing Loan program have acted as "seed money," stimulating almost five private dollars for every dollar the Federal Government lends. In 1985, $30 million of Federal loans for college housing resulted in projects with a total cost of over $160 million. (See Attachment) Many of these projects would not have taken place without the impetus of the Federal loans. Naturally, the economy in general, and particularly employment, benefit from this.

The College Housing Loan program is a quality program that has always been shared by public and private colleges, and that has benefited colleges and universities all over the country. The Authorization committees' bills allow the program to now address the problem of the nation's academic facility infrastructure.

On behalf of our President, Rev. Timothy S. Healy, S.J., we urge the Committee to support the College Housing Loan program. thank you for this opportunity to testify.

COLLEGE HOUSING PROGRAM

COLLEGE HOUSING LOAN AMOUNT	TOTAL PROJECT COST
1981 - $57,083,000	$ 70,626,393
1982 - 30,043,000	43,972,724
1983 - 29,978,000	50,602,221
1984 - 30,000,000	68,348,067
1985 - 30,413,000	160,803,265
TOTALS - $177,517,000	$394,352,670

WEDNESDAY, MAY 7, 1986.

MEDICARE CONTRACTORS

WITNESS

HARRY CAIN, BLUE CROSS AND BLUE SHIELD

Mr. NATCHER. Our next witness is Mr. Harry Cain, Administrator of the Federal Programs Division, and we will be pleased to hear from you, Mr. Cain.

Mr. CAIN. Mr. Chairman, I thank you. We have an extended statement for the record, and I will just quickly summarize what that says.

Mr. NATCHER. All right.

Mr. CAIN. At the end of our prepared statement, there are several graphs and charts. I would draw your attention to the two paragraphs or charts that show on pages 22 and 23.

They do summarize what the problem is in this program. The problem is essentially that the contractors in this program have not had sufficient funds to process all the claims they will receive in fiscal year 1986.

If the President's proposal is approved for 1987, that problem will become worse. I do not think I have to say anything about the problems that result from unprocessed claims in this important problem, but our formal statement does talk to that problem.

The second point I would like to raise is that HCFA has just come out and explained a new medicare policy of slowing up claims payment to average 30 days.

We think that is a very unwise policy, but even if it is adhered to, even if the Congress decides to support the slowing up of claims in this area, we are asking that there be a clear distinction between claims processing and claims payment.

To slow up claims processing raises all kinds of severe operational problems. It even prevents our being able to answer reasonable inquiries.

On the other hand, if the government chooses to slow down claims payments, it can, and it can do that without following up the claims processing itself, and we would urge that if this new policy is adhered to, that the medicare contractors be at least adequately funded to process all the claims received in fiscal year 1987.

Mr. Chairman, that concludes my summary.

[The statement of Mr. Cain follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE CONTRACTING BUDGETS

BEFORE SUBCOMMITTEE ON

LABOR-HHS

HOUSE APPROPRIATIONS COMMITTEE

BY

Harry Cain
Administrator
Federal Programs Division

May 7, 1986

Mr. Chairman and members of the Subcommittee, I am Harry Cain, Administrator of the Federal Programs Division of the Blue Cross and Blue Shield Association, the national coordinating organization for all Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield organization has been deeply involved in Medicare since the program's beginning 20 years ago. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for much of the day-to-day administration of this important program.

We appreciate the opportunity to appear before you on the subject of the Administration's FY 1987 budget request for Medicare contractor functions. This Subcommittee has long supported the idea that a strong administrative system is necessary to assure that the Medicare program achieves its objectives. During the last few years this Subcommittee has taken the lead in providing adequate funding for Medicare contractor activities. This support has been an important factor contributing to the successful implementation of numerous program changes and to the historically high level of service contractors have provided to beneficiaries.

The Medicare intermediary and carrier contractor structure has served the program and its beneficiaries well over the last 20 years. Medicare contractors' administrative costs, expressed as a percentage of benefit payments, have long been extremely low. They now represent about 1.3% of total Medicare expenditures and are continuing to decline. Medicare administrative costs have also declined significantly on a per claim basis. For example in FY 1978, the average cost of processing a claim was $4.06 for Part A and $2.84 for Part B. For FY 1986, HCFA estimates that unit processing costs will be $2.00 for Part A and $1.76 for Part B. Although we believe that as a result of Gramm-Rudman-Hollings reductions and other factors the FY 1986 levels are too low, we would note that the funding level originally appropriated by the Congress for FY 1986 would also have shown a significant decline from prior unit cost figures. We know of no other longstanding government contracting arrangement that rivals this level of efficiency.

In addition to its efficiency gains, the contractor system has also been effective at controlling Medicare benefit payments; responding to and dealing with beneficiaries and providers; and implementing complex legislative, regulatory, and administrative policy changes, all while coping with an ever growing volume of claims.

Severe funding restrictions for FY 1986, current budget and administrative priorities, and the prospects for inadequate funding for FY 1987 seriously threaten the continuation of this record of success. In particular, we are now seeing a deterioration in contractors' ability to provide quality service and timely processing of claims and bills. This has also been noted by the General Accounting Office in a recent report entitled "Medicare: Existing Contracting Authority Can Provide for Effective Program Administration."

The Administration's FY 1987 Budget Request

In our view, the Administration's FY 1987 budget request for Medicare contractors of $957 million plus a $50 million contingency fund is inadequate to meet the needs of the program. In fact, the amount requested for expected workloads is $6.7 million less than Congress considered adequate for the current year in the FY 1986 appropriation, yet the contractors will process more than thirty million additional claims in FY 1987, and inflation will increase contractor input costs. The Blue Cross and Blue Shield Association recommends a total funding level of $1.147 billion. Of this amount, we recommend that $602 million be specifically earmarked for claims payment and $244 million for program safeguards. At this funding level contractors should be able to clear up the large backlog of claims that will exist at the beginning of FY 1987 and process the 382 million new claims that will come in next year. At our recommended budget level contractors would also achieve greater paybacks in terms of benefit dollars saved than would be achieved under the Administration's budget request.

We have also developed estimates of the funding we believe would be necessary to achieve other levels of service.

Background

The Health Care Financing Administration (HCFA) divides the contractor function into four categories: program safeguards, claims processing, beneficiary and provider services, and productivity investments. Of these four categories, two -- program safeguards and claims processing -- comprise 85 percent of the total contractor budget.

The program safeguard category includes such functions as audit, medical and utilization review, and assuring that Medicare is the "secondary" payer whenever some other payer should be primary. Over the last several years, those program safeguard activities have received a reasonable level of funding and the results have been rewarding. HCFA estimates savings from these activities alone will exceed $1.7 billion in FY 1987. The payback ratios, in terms of benefit dollars saved versus administrative dollars spent, have ranged from 5:1 to 30:1 based on the type of activity performed. We believe that more funds can be effectively spent in these safeguard functions in FY 1987 than the Administration has requested, and our attached budget breakdown provides the specific numbers.

The other major category of contractor functions--claims processing--includes those activities necessary to process and pay promptly and accurately claims for Medicare covered services. The contractors' major challenges are to assure that the claims forms are understood and properly submitted, and then to run those claims through a myriad of screens and edits--both automated and manual--to assure that the services are covered and that the charges are reasonable. We perform these functions in accord with applicable law, regulations and detailed operating instructions issued by HCFA. These claims processing functions have demonstrated their value over the years by returning about $8 in benefit savings for every dollar spent on them. HCFA estimates savings from claims processing activities will exceed $8 billion in FY 1987. We are also proud to point out that while the function has become more and more complex we have steadily dropped the administrative costs per claim. Claims processing also provides the foundation for all the other program safeguard activities.

The amounts requested and allocated by the Administration to fund the major component of this critical function -- claims/bill payment -- have not kept pace with the increasing workload and the added complexities of the claims processing operation. Some key figures:

	FY 84	FY 85	FY 86	FY 87
TOTAL CLAIMS/BILLS WORKLOAD(in millions)	278.2	312.9	343.5	382.1
HCFA PROPOSED CONTRACTOR FUNDING FOR CLAIMS PAYMENT (in millions)	$566.4	$501.0	$508.2	$522.3

This table shows that during the FY 1984-FY 1987 timeframe claims volume has increased 37.4 percent while HCFA actual and proposed funding for claims payment has decreased by 7.8 percent. While productivity gains certainly can be expected in this area, the current state-of-the-art does not permit the achievement of gains of this magnitude.

Beneficiary and provider services represents the third category of contractor functions. This category includes the funding necessary for contractors to conduct hearings and reconsiderations for beneficiary and provider appeals; to respond to over 20 million written and telephone inquiries from beneficiaries and providers concerning the status of claims and other issues; and to communicate with providers regarding legislative and other changes in Medicare. In effect, Medicare contractors are the program's front line in dealing with over 33 million beneficiaries, 400,000 physicians, 7000 hospitals, 6,000 skilled nursing facilities, 5,600 home health agencies, 3,500 laboratories and other providers.

Unfortunate effects of the underfunding of claims processing have been that the quality of contractors' service to providers and to beneficiaries has begun to deteriorate. Claims processing times and backlogs are increasing significantly. Inquiries from providers and beneficiaries are increasing at a faster rate than ever before.

Clearly, contractors have not been able to maintain service and meet all of HCFA's performance expectations. HCFA's own measures of contractor performance clearly demonstrate this difficulty. In FY 1984, 21 percent of the Part A contractors and 21 percent of Part B contractors failed one or more of the "critical elements" in HCFA's Contractor Performance Evaluation Program. In FY 1985, the percent of contractors who failed one or more "critical elements" jumped to 74 percent in Part A and 66 percent in Part B.

Finally, there is a fourth category called productivity investments which includes funding for projects, such as the conversion from hard copy to electronic submission of claims, that can be expected to improve the efficiency of contractor operations. Here too, we believe that the Administration's budget underestimates the cost-saving value that more productivity investments can generate.

Impact of Gramm-Rudman-Hollings

We had hoped that FY 1986 would establish a reasonably adequate level of funding and a stable processing environment, and the congressional appropriations legislation for FY 1986 took a good step in that direction. However, the subsequent Gramm-Rudman-Hollings legislation forced a reduction in the FY 1986 funding level from $978.5 million to $937 million. Early this year, the Administration also proposed a further cut of $2.1 million in the FY 1986 funding level -- in the form of a rescission request -- in an effort to assure that the actual funding level did not exceed their original budget request. At this point, HCFA has allocated only $920 million for contractor budgets. Recently the Congress made more money available for certain Medicare contractor functions ($78 million in the Comprehensive Omnibus Budget Reconciliation Act of 1985) but as we explain later in this testimony, that is not likely to solve the FY 1986 claims processing problem.

The conference committee on the FY 1986 appropriations bill clearly understood the importance of the claims processing function. To quote from the pertinent part of the committee's report:

> ". . .The conferees direct that within the amount provided, adequate resources be allocated to basic claims processing activities to ensure that the backlog of unprocessed claims be reduced to the maximum extent possible, and that under no circumstances should it be allowed to increase. Further, the conferees direct that services to beneficiaries not be allowed to deteriorate. . ."

Subsequently, the Administration responded to the Gramm-Rudman-Hollings reduction by directing contractors to allow claims inventories to rise. The effects are beginning to be seen. For the first 5 months of FY 1986 the Part B claims backlog has increased by 37 percent over the closing backlog for FY 1985. Similar Part A statistics show an increase of 18 percent.

Effects of Increased Claims Backlog

In recent testimony before the House Ways and Means Subcommittee on Health, the Administration stated that its reasons for directing contractors to allow claims inventories to rise are twofold: First, by paying contractors to process fewer claims than they receive, the funding shortfall brought about by Gramm-Rudman-Hollings can be accommodated; and second, by building backlogs and slowing down claims processing, claims payment will be slowed and this will increase the interest earned on the Medicare Trust Funds. This has evolved into a newly enunciated Administration policy: a processing-and-payment cycle standard will be established at 30 days.

We have argued against that policy on the following grounds:

1) Building claims backlogs and slowing their processing does not save money, it generates:

   - more beneficiary and provider inquiries (which are both costly and frustrating; many inquiries cannot be answered if the claims in question have not been processed);

   - more duplicate claims (which also increase administrative cost);

   - slower flow of information to the PRO, slower feedback to providers/beneficiaries on medical review issues, more delay in determining whether Medicare should be the secondary payer, etc;

   - less margin for error; an otherwise small problem in the system, for example, can become a disaster if the backlogs are already high.

2) Slowing down claims payment (as distinguished from claims processing) can clearly save money, but it also has costs that should be recognized:

- There is no free float. To the extent the government saves money by delaying payment, beneficiaries and providers pay the cost;

- The policy falls with different weight on different kinds of providers. For example, those providers under Part A who are on periodic interim payments (PIP) will be least affected. Physicians who accept "assignments" under Part B will be adversely affected; physicians who demand payment by beneficiaries at the time of service will not be affected but beneficiaries will be;

- Inquiries and duplicate claims submission will increase and this will increase administrative costs.

We believe that making specific program changes would be a more appropriate approach to deficit reduction than delaying claims payment.

If the government does go forward with a policy of delaying payment of claims, we recommend that it:

- clearly separate claims processing from claims payment -- it is more efficient and less disruptive for contractors to process all claims received and then delay payment than not to process large numbers of claims.

- clearly and publicly explain the new payment policy;
- anticipate that the policy will generate a larger volume of costly inquiries for a long time to come (in spite of public explanations);
- realize that to make the 30 day standard a reality for the great majority of claims -- and not just an average with wide variations around it (which would be even harder on those groups of beneficiaries and providers whose claims are most difficult to process) -- claims processing would have to be adequately funded.

Parenthetically, on the private side of our business, we set different payment cycles (usually faster than 30 days) depending on our agreements with providers (e.g., speed of payment varies with amount of discount), or on the terms of our contracts with major accounts. I do not believe that private insurers would ever deliberately build backlogs of unprocessed claims as a management device either to cut costs or to slow down payments.

The eventual effect of HCFA's implemention of this new policy should be noted: by the end of FY 1986, Part A intermediaries will have a backlog of 16 days work on hand with a conservative estimate of 1,062,000 bills pending over 30 days. Part B carriers are likely to have 18 days work on hand and 2,676,000 claims pending over 30 days. Contrasted with the fourth quarter of 1984, Part A bill inventories pending over 30 days will have increased by 530 percent, while overall Part A inventories will have increased by 259 percent. Part B claims inventories over the same period pending for over 30 days will have increased by 163 percent while overall inventories will have increased by 161 percent. Appended to this testimony are some charts that depict the situation.

FY 1986 and COBRA

On April 7, the President signed the Comprehensive Omnibus Budget Reconciliation Act of 1985 which provided additional funding for Medicare contractor functions in FY 1986. That funding, however, is earmarked for certain activities other than ongoing claims processing. An additional $60 million annually was made available for the next three years for audit, medical and utilization review and Medicare secondary payer activities and $18 million was authorized this year for activities relating to the participating physician and fee freeze provisions.

While the availability of these new earmarked funds conceivably could enable a reallocation of existing funds to eliminate the shortfall in claims processing, HCFA has not yet announced how, or when, it will allocate these new monies. We would expect that about $20 million will have to be reallocated to implement program changes mandated in COBRA. Based on the budget policy that seems implicit in the Administration's rescission request and its objective of saving interest on trust fund monies by directing contractors to process fewer claims than they receive, we doubt that any significant funding will be directed to ongoing claims processing activities. We believe that a failure to reallocate significant funding to claims processing would be a serious mistake. Moreover, the continued delay in the release of the COBRA funds makes it extremely difficult for contractors to take appropriate management actions for this fiscal year.

It should be noted that several contractors have given HCFA formal notice that at current rates of expenditure for the assigned tasks, funds for some claims processing activities will be exhausted prior to the end of FY 1986. When faced with similar situations in the past, contractors continued to work, confident that funds eventually would be made available to reimburse them for their efforts. However, in FY 1985 Blue Cross and Blue Shield contractors spent approximately $12 million of their own funds in excess of HCFA budget approvals, mostly to keep the claims process running smoothly. These contractors have been told that they will not be reimbursed for such budget overages. As a result, contractors are more and more hesitant to commit to a continuation of work without assurance of reasonable and timely payment.

Conclusion

We believe the problem is a basic one: there simply has not been an appropriate allocation of funds for the most basic of contractor functions: claims processing. (The recently released GAO report on this subject supports this conclusion.) In our judgment, the Administration's FY 1987 budget request would again result in underfunding the claims processing functions and a further deterioration of service.

For these reasons the Blue Cross and Blue Shield Association urges your favorable consideration of a budget for Medicare contractors for FY 1987 which will return service to FY 1984 levels. We estimate $1.147 billion will be needed. A detailed analysis and justification for our estimate which also includes recommendations for increases and decreases in specific line items is attached.

Medicare Contractor Budget
FY 1987 Comparisons
(Dollar Amounts in Millions)

	HCFA/OMB FY 1987	BCBSA Estimates				
		Recommendation	Recommended Increase (Decrease)	Explanation Code	Alternative I	Alternative II
Payment Safeguard						
Medical Review - A	$ 43.6	$ 36.3	($7.3)	A	$ 36.2	$ 35.9
Medical Review - B	47.0	67.2	20.2	B	67.2	67.22
	$90.6	$103.5	$12.9		$103.4	103.1
Provider Audit						
Desk Review	$17.9	$ 24.6	$ 6.7	C	$ 24.6	$ 24.6
Field Audit	49.4	67.0	17.6	D	67.0	67.0
Settlement	13.3	16.8	3.5	E	16.8	16.8
Total Audit Related	$80.6	$108.4	$2.8		$108.4	108.4
Medicare Secondary Payer	$ 28.1	$ 31.9	$ 3.8	F	$ 31.9	$ 31.9
Total Payment Safeguards	$199.3	$243.8	$44.5		$243.7	$243.4
Productivity Investments	$29.7	$40.0	$10.3	G	$40.0	$40.0
Claims Processing						
Bill/Claims Payment	$522.3	$601.8	$79.5	H	$588.4	$575.8
Provider Reimbursement	23.8	29.1	5.3	I	29.1	29.1
Printing	1.5	1.5	0.0		1.5	1.5
Fixed Price/Incentive Contracts	62.0	62.0	0.0		62.0	62.0
Total Claims Processing	$609.6	$694.4	$84.8		$681.0	668.4
Beneficiary and Provider Services						
Hearing and Reconsiderations	$ 26.4	$ 30.0	$3.6	J	$ 30.0	$ 30.0
Elim. Favorable Waiver Presumption	12.8	5.0	(7.8)	K	5.0	5.0
Beneficiary Communications	63.8	65.3	1.5	L	75.0	75.0
Participating Physicians	15.2	18.0	2.8	M	18.0	18.0
Total Beneficiary & Provider Services	$118.2	$118.3	$0.1		$128.0	$128.0
Operating Funds	$ 956.8	$1,096.5	$139.7		$1,087.7	$1,079.8
Contingency Funds	50.0	50.0	0.0		50.0	50.0
	$1,006.8	$1,146.5	$139.7		$1,137.7	$1,129.8
TOTAL CONTRACTOR BUDGET	$1,007.0	$1,147.0	$140.0		$1,137.0	$1,130.0
Workload Consequences						
Part A: Bills Processed	65.8 mm	70.2			68.7	67.6
Days Work on Hand	22.9 days	6.0			16.0	16.0
Part B: Claims Processed	316.3 mm	339.9			323.3	324.7
Days Work on Hand	24.6 days	6.0			12.0	18.0

EXPLANATION

A. The Administration is proposing an increase of $11.4 million, or 35 percent over FY 1986. A major factor is the increase in medical review of HHA claims resulting from HCFA's Forms 485 and 486. At this time, we do not believe that this level of review will be required on an ongoing basis or that it will be cost effective.

B. The Administration has proposed a major decrease in medical review investments from FY 1986. The proposed decrease is $11.7 million or 20 percent. Medical review efforts in Part B are highly cost effective, achieving approximately 8 to 1 payback, and we find no rationale to support the proposed reduction. Our proposal for $67.2 million is based on claim growth and inflation from FY 1986 funding level of $58.7 million.

C. The Administration's proposal amounts to a reduction of $2.7 million from 1985 or 13 percent. Delays in the development of the cost report forms have produced backlogs which have been amplified by the growth in participating providers. Our proposal contemplates reducing the backlogs.

D. The Administration's proposal amounts to a reduction of $12.7 million or 20 percent from FY 1985. FY 1986 expanded audits of PPS-I hospital cost reports has resulted in accumulations of unaudited cost reports and unrecovered funds. Our recommendation contemplates reducing the backlog of unaudited cost reports.

E. The President's FY 1987 budget proposal is $1.5 million or 10 percent less than FY 1985 costs. Given the backlogs in cost reports, it is essential that adequate funding be made available to the contractors in FY 1987 and FY 1988 to achieve currency in audits.

F. There is no area which offers greater potential for timely cost avoidance savings than Medicare secondary payor efforts. In Part A contractors are earning over $30 in savings for every dollar spent on these activities. These additional funds would accelerate recoveries and would, conservatively, save $110 million.

G. Our recommendation of $40 million is $10.3 million more than the Administration's proposal and is based on HCFA's pending project list, the impact of COBRA, anticipated systems projects, the impact of incorporating capital costs into DRGs and potential legislation. During FY 1985 and FY 1986 we have been forced to postpone systems improvements due to tight financial constraints.

H. We are recommending an investment of $601.8 million in bill/claims payment as compared to the Administration's $522.3 million. Inadequate funding in FY 1985, and further reductions in FY 1986, have resulted in inappropriate claims backlogs and delays in payment. Major increases in pending claims are occuring in FY 1986. The Administration's budget proposal for FY 1987 would result in another 40 percent increase in pending/unpaid-claims.

Every effort must be made to ensure timely processing and payments to beneficiaries and Providers.

I. The Administration's proposal for FY 1987 is $23.8 million, or only 3.5 percent more than FY 1985 costs. The major growth in participating providers, due to PPS and new home health agencies, and inflationary factors, requires $29.1 million for FY 1987.

J. The Administration has proposed $26.4 million for FY 1987 as compared to contractor costs of $33.1 for FY 1985. During FY 1986, the Administration has reduced funding to $23.3, which has resulted in near crisis situations on backlogs of pending appeals. Our recommendation for $30.0 million should improve service to beneficiaries and Providers.

K. Subsequent passage of COBRA has materially reduced the potential incidence of appeals from Home Health Agencies and Skilled Nursing Facilities. We believe that $5.0 million will allow the prompt processing of other appeals.

L. Prompt and accurate responses to beneficiary, physician and provider inquiries are essential. During FY 1986, HCFA reduced contractor funding by $2.8 million while claims backlogs and beneficiary inquiries were growing rapidly. The Administration's proposal for $63.8 million for FY 1987 is grossly inadequate given their proposal to delay claims processing increase Medicare pending bills by 40 percent. Our recommendation of $65.3 is predicated on additional funding for bills/claims payment and a major reduction in pending/unpaid claims. Failure to provide adequate funding for bill/claim payment will result in greater costs for beneficiary communications which could grow to $75.0 million.

M. Our recommendation of $18.0 million for physician fee freeze/participating physicians is consistent with the funding in COBRA.

Medicare Contractors
Bill/Claims Payment

Recommendation

Our recommendation for FY 1987 funding for Bill/Claim Payment at $601.8 million reduce the number of pending claims by more than 15 million.

	Pending 9/30/86	FY 1987 Receipts	To Be Processed	FY 1987 Processed	Pending 9/30/87
Part A	3,974,400	67,853,568	71,827,968	70,248,768	1,579,200
Part B	20,692,800	326,761,589	347,454,389	339,863,189	7,591,200
	24,667,200	394,615,157	419,282,357	410,111,957	9,170,400

This level is recommended to restore unpaid claims/bill backlogs to a reasonable level while assuring prompt payment to beneficiaries, physicians and providers. At this level, we anticipate a savings of $9.7 million in Beneficiary Communications cost due to avoided inquiries and complaints from beneficiaries, physicians and providers.

Pending backlogs of unpaid claims at the Administration's requested funding level would produce major complaints from all claimants. Funding at our recommended level would restore optimum service and processing capabilities - levels that have proven to be satisfactory and responsive to beneficiary and provider needs and requirements.

Medicare Contractors
Bill/Claims Payments

Alternative I

An alternate funding plan for bill/claim payment could be based on the concept of maintaining the February 28, 1986 pending workloads (17,533,117 million claims). However, the mechanics of this alternative would result in an increase in the number of claims pending. The workloads and pending inventory would be:

	Pending 9/30/86	FY 1987 Receipts	To Be Processed	FY 1987 Processed	Pending 9/30/87
Part A	3,974,400	67,853,568	71,827,968	60,669,568	3,158,400
Part B	20,692,800	326,761,589	347,454,389	332,271,989	15,182,400
	24,667,200	394,615,157	419,282,357	400,941,457	18,340,000

Alternative I would reduce the bill/claims payment funding by $13.4 million from our recommended funding level. However, contractor communications costs for handling additional beneficiary inquiries and complaints would increase by $4.7 million.

Medicare Contractors
Bill/Claim Payment

Alternative II

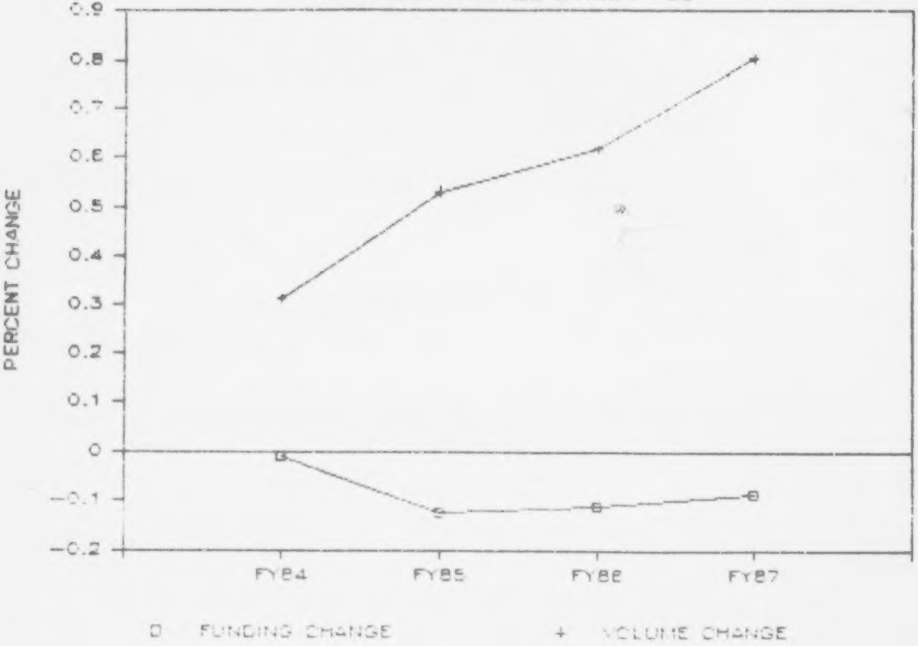
Another alternate funding Plan for bill/claims payment could be based on the concept of acknowledging HCFA's projected growth in backlogs for FY 1986. Unfortunately, our current growth of receipts in bill/claims is exceeding HCFA's original estimates and processing the 382.1 million claims in HCFA's plan would provide for an increase in pending claims:

	Pending 9/30/86	FY 1987 Receipts	To Be Processed	FY 1987 Processed	Pending 9/30/87
Part A	3,974,400	67,853,568	71,827,968	67,616,768	4,211,200
Part B	20,692,800	326,761,589	347,454,389	324,680,789	22,773,600
	24,667,200	394,615,157	419,282,357	392,297,557	26,984,800

Alternative II would result in further beneficiary, physician and provider complaints which would increase the cost of servicing those complaints by $5.0 million. Those costs would be minimal in comparison to those resulting from accepting the Administration's budget since it would allow pending claims to increase by an additional 51 percent above the FY 1986 levels.

FUNDING AND VOLUME LEVELS

PERCENT CHANGE SINCE FY 83



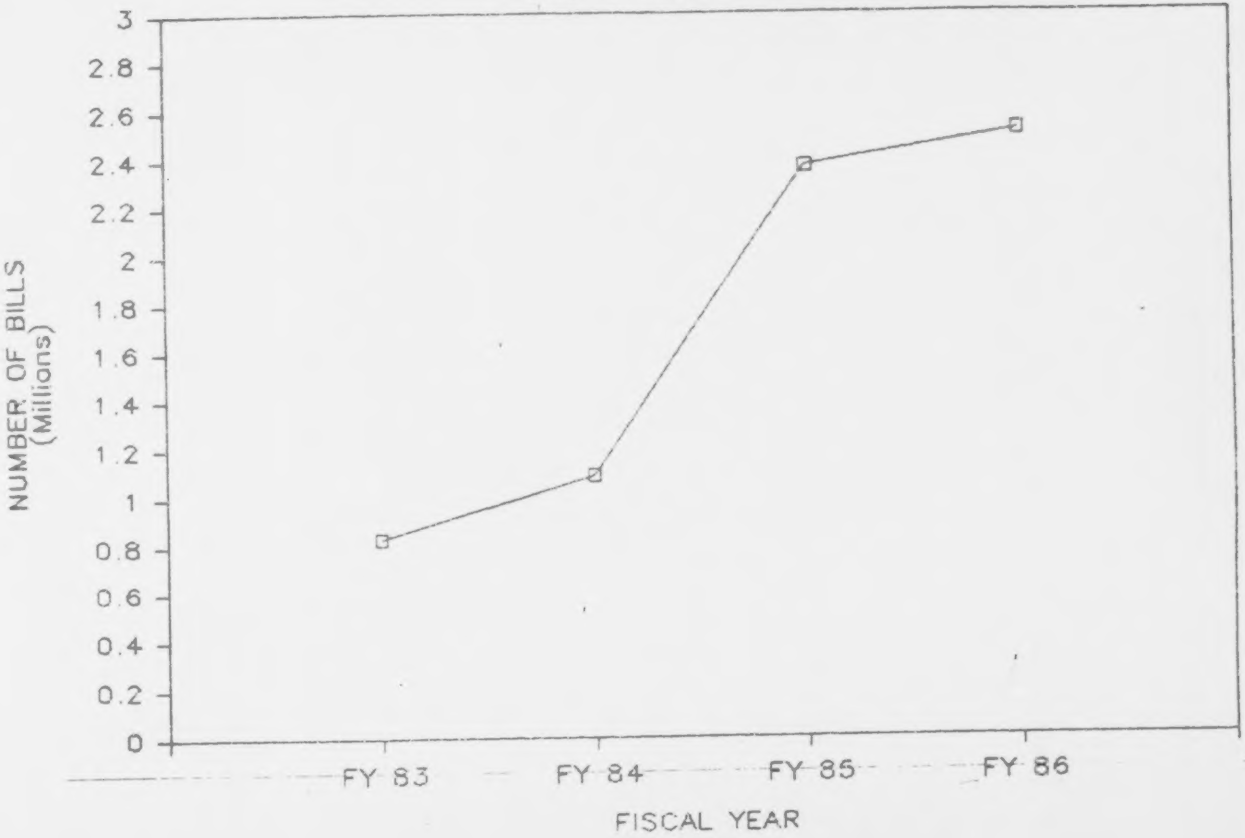
FUNDING VS. VOLUME
FY 84 TO FY 87

FISCAL YEAR	MEDICARE PARTS A & B VOLUME	PERCENT CHANGE IN VOLUME (1)	CLAIMS PROCESSING FUNDING	PERCENT CHANGE IN FUNDING (1)
FY84	278,200,000	31.18%	$566,400,000 (2)	-1.00%
FY85	324,700,000	53.10%	$501,000,000 (2)	-12.43%
FY86	343,500,000 *	61.97%	$508,200,000 (3)	-11.17%
FY87	382,100,000 *	80.17%	$522,300,000 (4)	-8.70%

* Projected
(1) Since FY 1983
(2) Administration Request
(3) As of 4/1/86
(4) HCFA Allocation

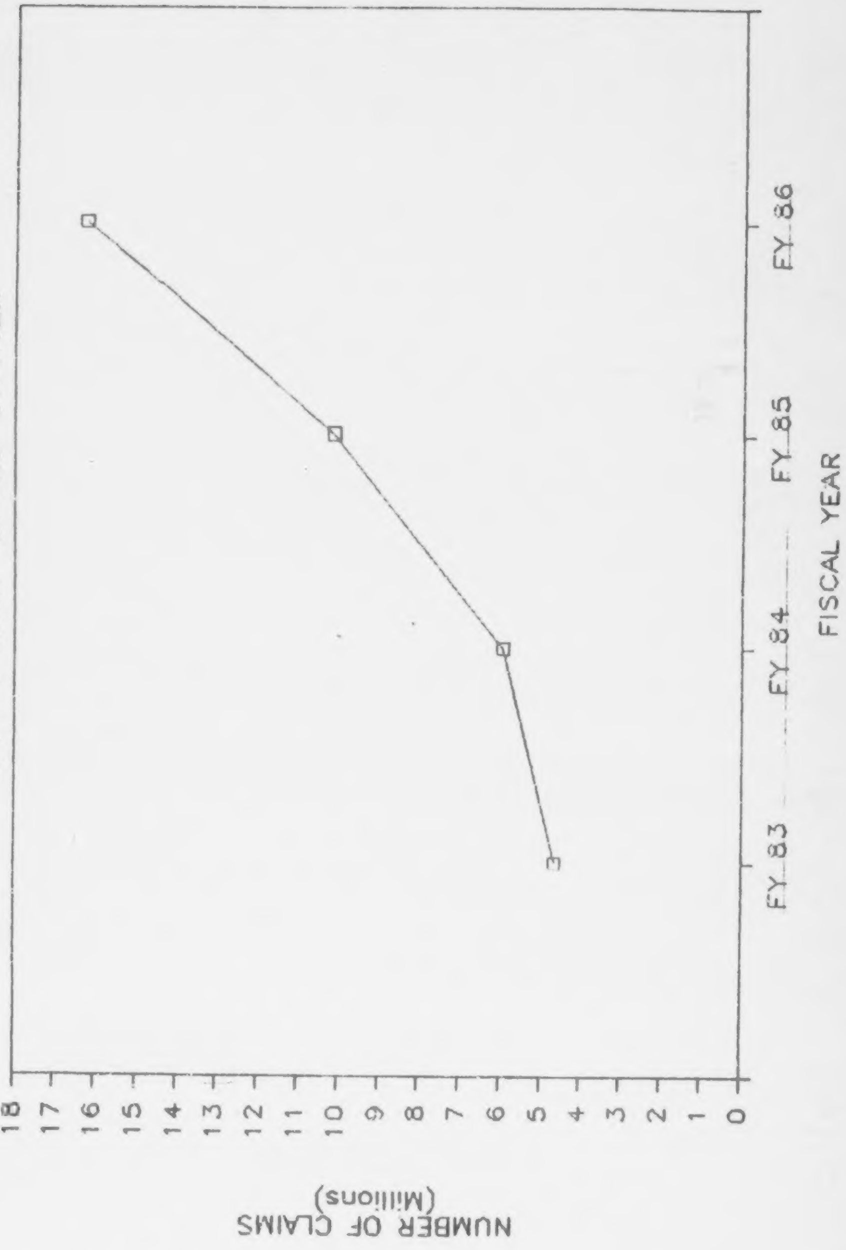
PART A ENDING INVENTORY

END OF 2ND QUARTER



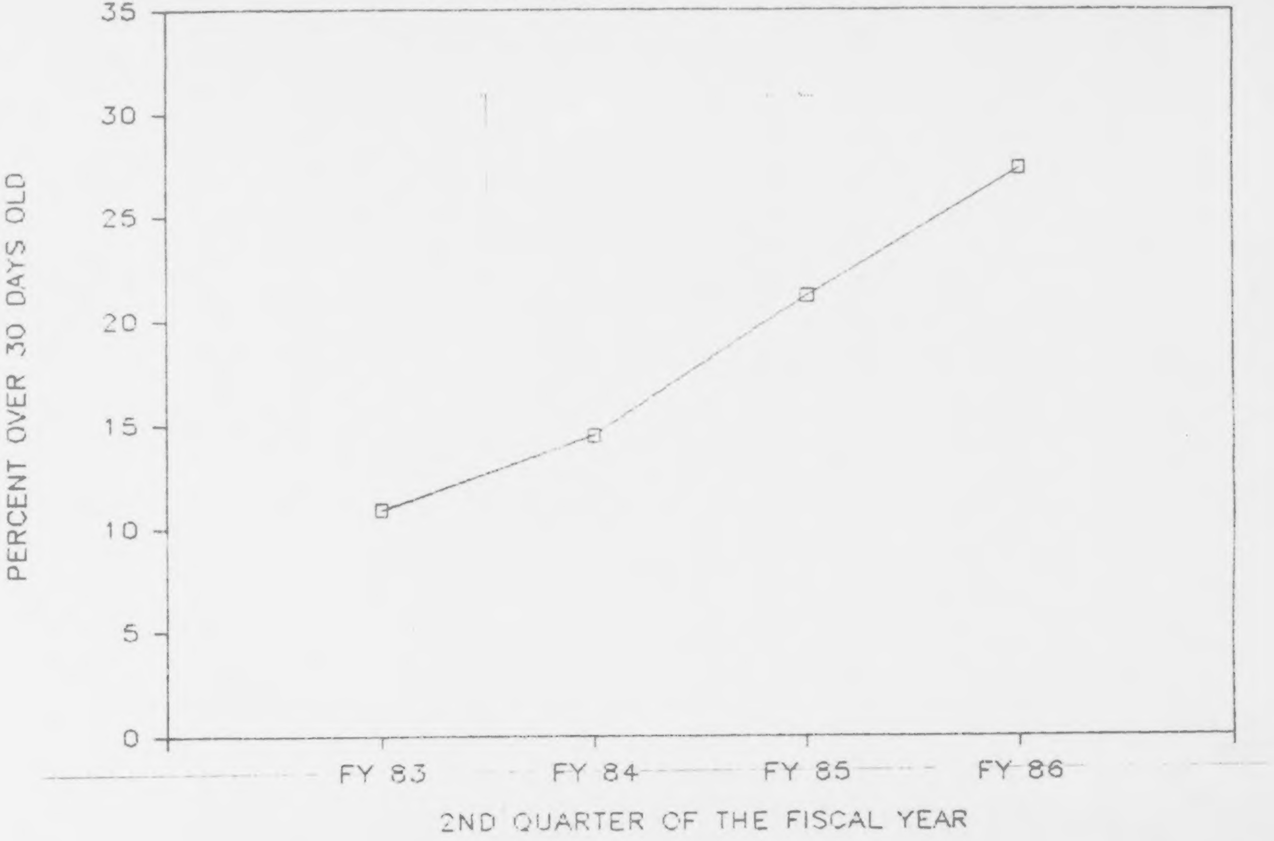
PART B ENDING INVENTORY

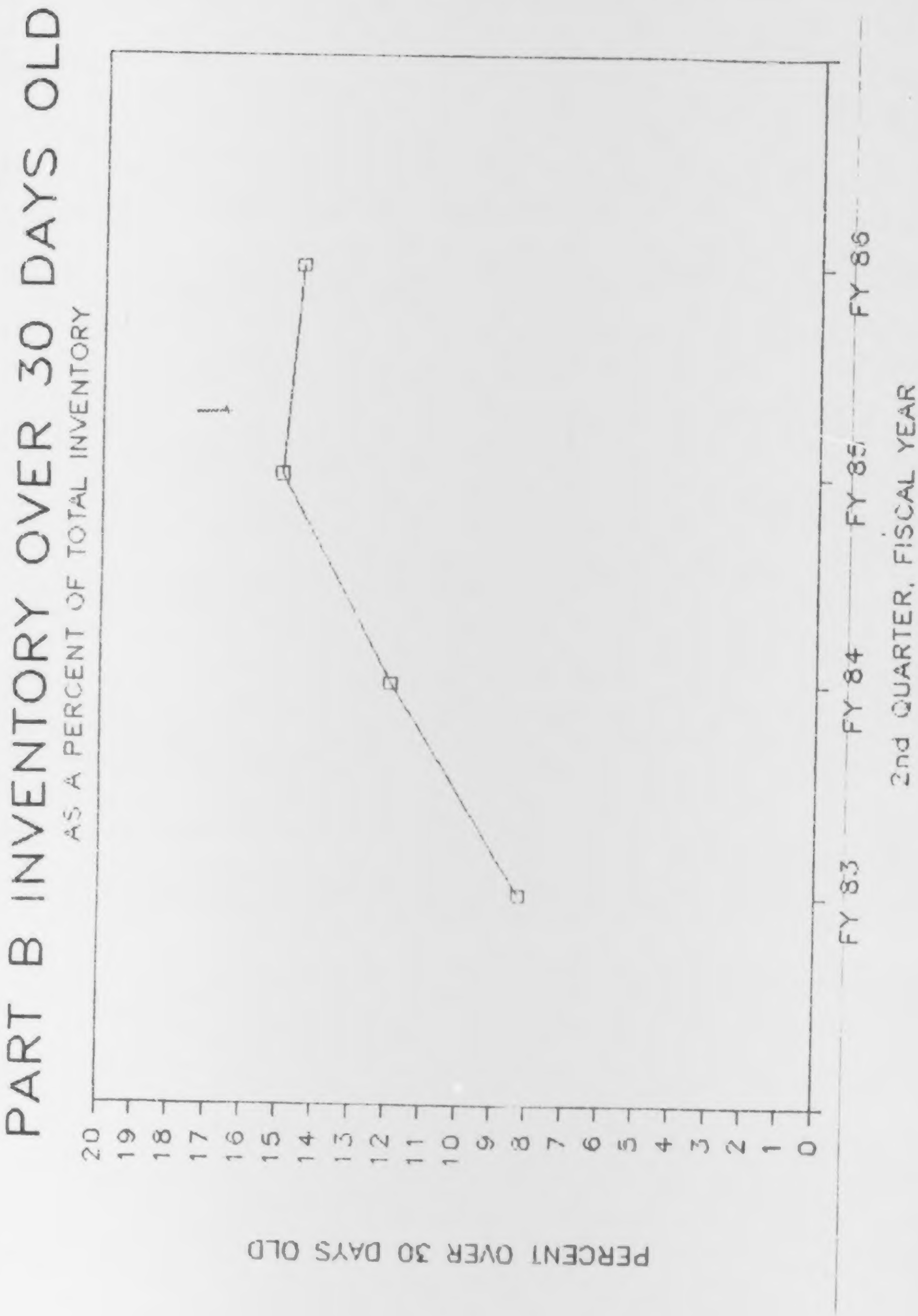
END OF EACH SECOND QUARTER



PART A INVENTORY OVER 30 DAYS OLD

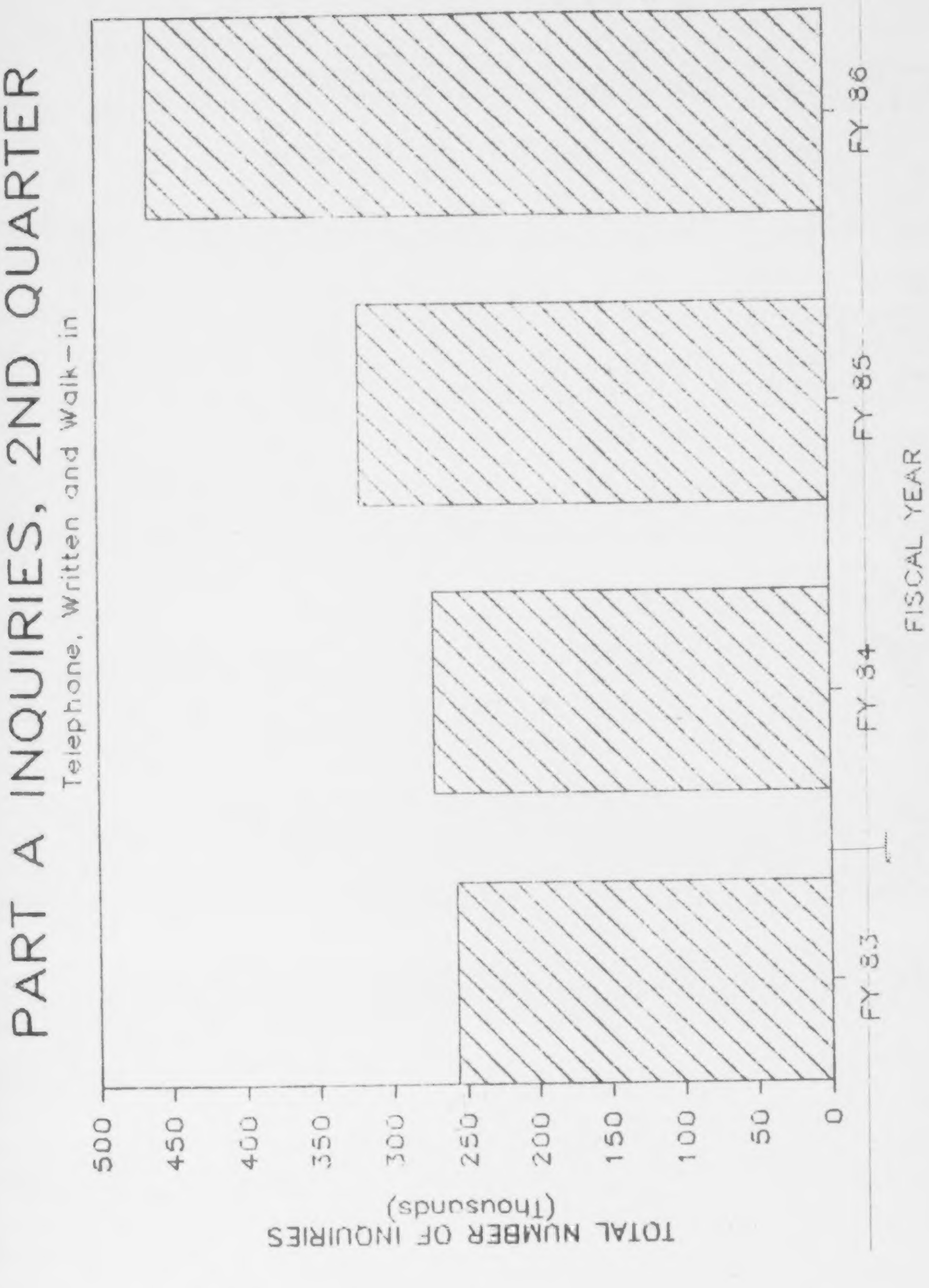
AS A PERCENT OF TOTAL INVENTORY





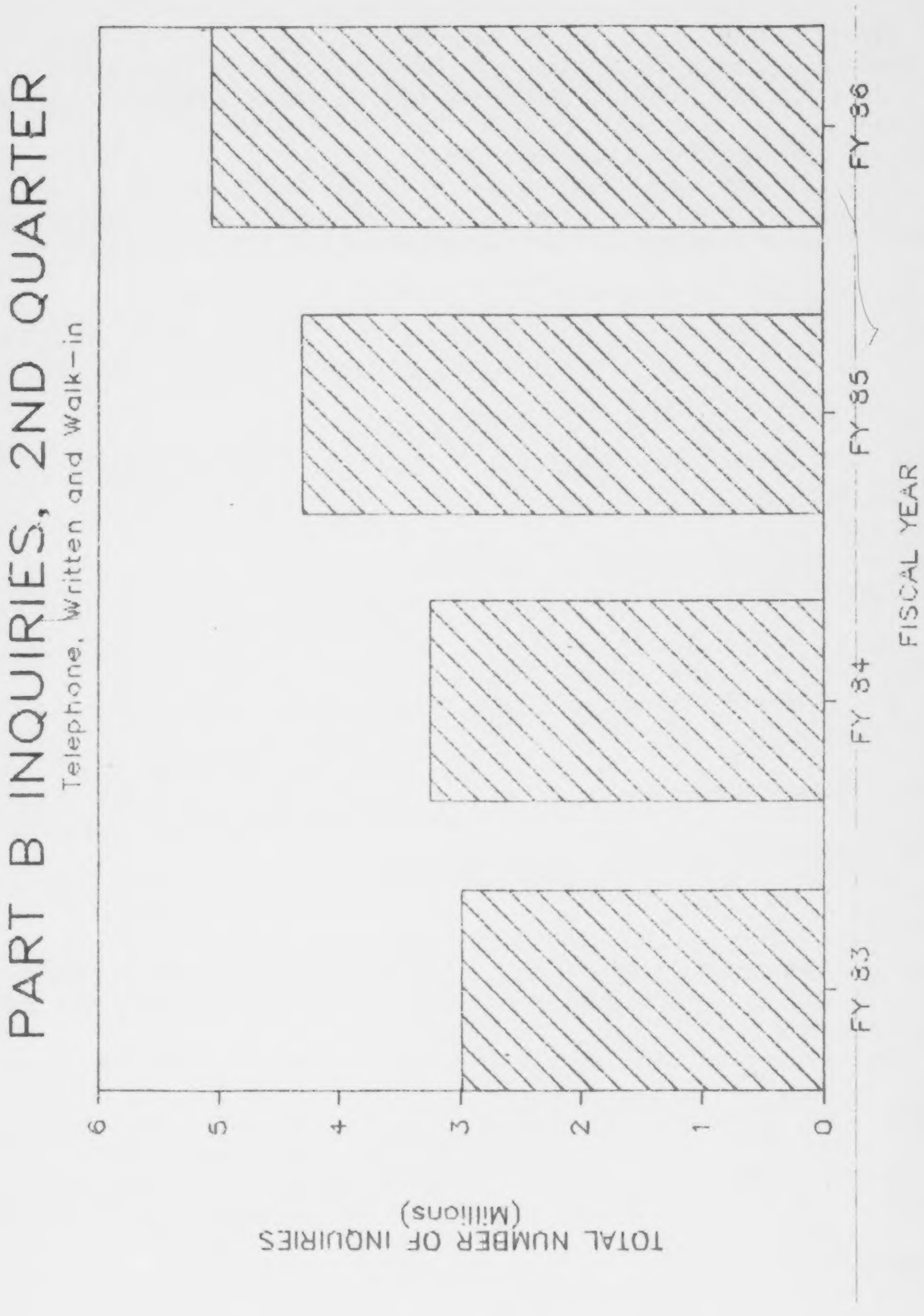
PART B INVENTORY OVER 30 DAYS OLD

AS A PERCENT OF TOTAL INVENTORY



PART A INQUIRIES, 2ND QUARTER

Telephone, Written and Walk-in


PART B INQUIRIES, 2ND QUARTER
Telephone, Written and Walk-in
TOTAL NUMBER OF INQUIRIES (Millions)
0
1
2
3
4
5
6
FY 83
FY 84
FY 85
FY 86
FISCAL YEAR

Mr. NATCHER. Mr. Cain, let me ask you, do you have a figure in there as to proposed increase over the request? Is it $141,000,000?

Mr. CAIN. Yes, it is. It is $40,000,000 of which a little over half would go into claims processing. That is an increase over the request including the contingency fund.

Mr. NATCHER. I understand.

Thank you very much, Mr. Cain. You have made an excellent statement. We appreciate your appearance before the committee.

WEDNESDAY, MAY 7, 1986.

RETT SYNDROME

WITNESSES

DR. ALAN SMITH, THE INTERNATIONAL RETT SYNDROME ASSOCIATION
GAIL SMITH
KRISTI SMITH
KATHY HUNTER
STACIE HUNTER

Mr. NATCHER. Mr. Hoyer, I yield to you at this time, if you would like to present these next witnesses.

Mr. HOYER. I appreciate that very much. I would like to ask Dr. Smith, Gail and Mrs. Hunter to come forward.

Mr. Chairman, you will recall last year, this committee was kind enough to include a sum of money in the NIH budget, but not a specific sum to deal with Rett Syndrome. Mr. Early was very helpful on this.

Rett Syndrome, as is described in a brochure that you will be given—Gail Smith, Secretary of the International Association of Rett syndrome, and Mrs. Hunter to her left, who is the President of the Association, will be describing it as a neurological disorder which, unlike most, occurs after the first 6 to 18 months of normal growth in a child.

There are pictures. Kristi is seated between her father, Dr. Alan Smith, and her mother, Gail. Kristi, is a delightful young woman. She is just a joy to know, and we go to church together, and we see her regularly.

Rett Syndrome has only recently been identified. It was identified by an Austrian doctor named Rett. As a result of the monies that this committee set aside, Johns Hopkins University had a very successful conference this past fall on Rett Syndrome, and we are very excited about the progress.

Without further introduction, I would like to yield to Gail Smith, my good friend and the mother of Kristi.

Mr. NATCHER. Thank you, Mr. Hoyer.

Mrs. Smith, we will be pleased to hear from you.

Mrs. GAIL SMITH. Thank you, Mr. Chairman.

My name is Gail Smith, Secretary of the International Rett Syndrome Association, and the mother of a Rett Syndrome daughter.

Mr. Chairman, I appreciate this opportunity to summarize my previously submitted testimony which addresses the dire need for appropriations for research and awareness of Rett Syndrome.

First, I would like to thank Congressman Hoyer of Maryland for bringing Rett Syndrome to the attention of this committee last year. As a direct result of the committee's consideration, a report on Rett Syndrome was prepared by the NICHD and NINCDS and presented to this year's subcommittee.

Also, the highly successful Second International Conference on Rett Syndrome, held in November 1985 at the John F. Kennedy Institute in Baltimore, Maryland, was partially funded by these two Institutes. I thank the committee for their response to the need for such efforts.

I speak to you today as a parent who has felt the loneliness and isolation of watching our once normal, beautiful baby girl deteriorate mentally and physically. I have lived the fear and desperation, groping for a name of this dread disease that stole blindly what I did not want to give. I have waited, helplessly watching her experience frustration and fright as her body and her mind slipped away.

The process started when she was about one year old. We sought the help of many, many specialists around the country. Literally hundreds of tests yielded no answers.

My husband, a pediatrician, and I had spent endless hours seeking a diagnosis, and finally in January 1985, Dr. Andreas Rett of Vienna, Austria offered us the first and only diagnosis: Rett Syndrome.

Our daughter was almost 13 years old and at least we had a diagnosis. Tears welled in my eyes and I struggled to keep them back. All those years of watching and waiting, the fear in my child's face as she endured test after test, all the times we were told she was a mystery, "one of a kind," and we were not alone after all.

First described in 1965 by Dr. Andreas Rett, it was not until almost 20 years later that any information about Rett Syndrome was printed in English.

Currently, 300 cases have been diagnosed in the United States. Based on Swedish prevalence studies of 1 in 15,000 female births and accounting for one-quarter of all severe mental retardation in girls, there is a high probability that there are 8,000 cases of Rett Syndrome in the U.S. that are currently undiagnosed due to a lack of public and professional awareness.

Without the knowledge that this syndrome exists, physicians fail to diagnose this clinical picture as an entity. With an awareness emphasis, the possibility of diagnosing 8,000 cases in the U.S. is a realistic one.

Girls afflicted with the syndrome are normal until 6 to 18 months of age, then arrest in development. Regression leads to autism, seizures, severe retardation, and slowing of head growth. Purposeful hand use is lost and stereotypic "hand-wringing" movements become prominent.

With increasing age, symptoms include spasticity, curvature of the spine, poor circulation and loss of mobility.

To date, laboratory investigations have not revealed a cause for Rett syndrome, but there is a suggestion that as the syndrome is confined to girls, a genetic basis involving one of the X chromosomes may be indicated.

The need for finding a biological marker must be emphasized. Now, the diagnosis of Rett syndrome is purely a clinical observation and an evaluation of the medical life history of the child.

One must dream of not only finding a biological marker on existing cases, but then applying the findings to neonatal, and perhaps prenatal situations, leading to earlier and earlier recognition of the presence of this illness.

As in most cases, it is hoped that the earlier Rett syndrome is detected, the better the chance of the child to receive the benefits of intervention, when and if treatment is discovered.

I cannot stress enough that Rett syndrome girls develop normally until 6 to 18 months of age. By identifying the cause, determining a biological marker, and testing all new-born females, there is the opportunity for potential treatment, affording baby girls testing positive for Rett syndrome a normal life.

With respect to therapeutic intervention, the need for applied research, whether it be medical or educational, is extremely important to the well-being of existing cases. Research data of education programs and specialized therapy techniques are desperately needed to tap into what knowledge seems to lie behind the brightness of their eyes and to maintain physical use of their bodies.

More research is needed in all areas to give further insight into the syndrome. Research funding needs must be met, not only in print, but in actuality.

The International Rett Syndrome Association is available to work with the NICHD and the NINCDS to lend support, data and information regarding Rett syndrome cases of which we have knowledge. We keep an up-to-date geographical index of all Rett syndrome patients known to us, in the hope that this information will prove useful to further study.

For too long, the recognition of this disease as a distinct entity has been hidden. We have lost 20 years of potential research knowledge and this has caused many, many families to be severely burdened trying to find a diagnosis.

As with any progressive disease, there is an evolutionary process of acceptance that takes place as symptoms of the child manifest. No parent is ever prepared to hear that their child has not only become handicapped, but that the disease is degenerative.

The ramifications of what this might mean, not only in terms of the child's life, but in the whole scope of the family's life thereafter are incomprehensible.

Some families have coped and endured the strain, some could not. The turmoil is not without great emotional and financial expense. Now is the time to find the answers to our long-held questions about our precious daughter's developmental disabilities.

There may be only a thread of hope for my daughter, but perhaps for another child, there can be a miracle some day. As long as there is life, there is hope.

Mr. Chairman and members of the committee, thank you. We are happy to respond to any questions you may have.

Mr. **Natcher**. Thank you very much, Mrs. Smith. You made an excellent statement, and we want to thank all of you for appearing before our committee at this time.

[The statement of Mrs. Gail Smith follows:]

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RETT
SYNDROME
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Dr. Franz Seitelberger
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Dr. Jan Wahlstrom
Goteborg, Sweden
Dr. Michele Zapella
Siena, Italy

STATEMENT OF

Gail Smith

On behalf of

The International Rett Syndrome Association

Accompanied by

Kathy Hunter

Presented to
The Subcommittee On

Labor, Health and Human Services,

Education, and Related Agencies

Committee on Appropriations

United States

House of Representatives

On

April 24, 1986

2:20 P.M.

8511 ROSE MARIE DRIVE ■ FORT WASHINGTON, MD 20744 ■ 301/248-7031

Portrait of a Rett's Child

Bright eyes
Sweet smile
Clasped hands
Unique style

Special child
Secret mind
Loving heart
One of a kind

So we thought
But 'tis not true
Now we find
She is one of a few

Gail Smith

To My Baby of Thirteen Years

Sweet baby girl
Allow me a glimpse inside your mind
I want to understand why you smile
Why are your eyes so bright
Yet so troubled
Why do you cry
And I cannot comfort you

You are my joy
And you are my burden
I long for the comfort of knowing
Where this path will lead you
And that you will never suffer
The agony and the ecstacy
Is your small life symbolic of this

Thrust into life's complexities
We will trudge the road together
And emerge victorious
For Heaven's gates are open wide
And all are equal there
We shall walk hand in hand
And run and play and sing

You have taught me how to cry
And how to laugh
What is important
And what is not
You have taught me a new
  dimension of love
You trust me to care for you
And I strive to fulfill your entrustment

Now, close your beautiful eyes
And I'll kiss your rose petal cheek
As a tear slips silently from my
  glistening eyelash
To rest on your silken brow
Bonding us together
You smile
My heart is overwhelmed
God will watch over and give me
  respite for this night

I love you,

"Mama"

Gail Smith
June 1, 1985

Kristi Smith
5 mos
7 mos
13 mos
22 m
2 yrs
26 mos
27 mos
29 mos
4 yrs
5 yrs 4 mos
8 yrs 4 mos
10½ yrs
13½ yrs
13½ yrs

Kristi Smith, 13½ yrs.

My name is Gail Smith. I am a member of the charter Board of Directors and Secretary of the International Rett Syndrome Association. But, more importantly, I am the parent of a Rett syndrome daughter, who is now 14 years old.

Mr. Chairman, I appreciate this opportunity to testify of the need for appropriations for research and awareness of Rett syndrome.

First, I would like to thank Congressman Hoyer, of Maryland, for bringing Rett syndrome to the attention of this Committee last year. As a direct result, the Committee asked that a report on Rett syndrome be prepared by the National Institute of Child Health and Human Development, and the National Institute of Neurological and Communicative Disorders and Stroke, to be presented for this year's Subcommittee's review. Also, as a result of positive influence last year, the Second International Conference on Rett syndrome, held in November 1985 in Baltimore, Maryland, was partially funded by the NICHD and the NINCDS. The conference was highly successful in bringing together internationally renowned scientists, allied health and education professionals, and parents to discuss and exchange knowledge and research efforts. I thank the Committee for their response to the need for such efforts.

The following few paragraphs I share with you, as they exemplify the dire need for awareness, diagnosis and research of Rett syndrome:

> I speak to you today as a parent who has agonizingly watched our once normal baby girl slowly become severely mentally and physically debilitated, unable to feed or care for herself in in any respect.
>
> Our daughter was born in April 1972, a healthy, beautiful baby, the product of a normal pregnancy. She reached her early developmental milestones with ease, but at 10 months of age I

began to suspect something was wrong, and at 18 months of age we came to convince the doctors of the same. Although she was walking, something was amiss. This was the beginning of our walk down a lonely path of despair that lasted over a decade.

She was seen by many, many specialists and underwent literally hundreds of tests over the years, but she was never diagnosed. We were told repeatedly that she was "one of a kind." How quaint to be unique, but not when it applies to your child who is fading before your very eyes. Anguish and heartache are mild words to describe how we felt, to say nothing of the torment she must have endured having her body and mind slip away.

My husband, a pediatrician, and I had spent endless hours seeking a diagnosis, and finally in January 1985, Dr. Andreas Rett, of Vienna, Austria, offered us the first and only diagnosis - Rett syndrome. Our daughter was almost 13 years old, and at last we had a diagnosis. Tears welled in my eyes and I struggled to keep them back. All those years of watching and waiting, the fear in my child's face as she endured test after test, all the times we were told she was a mystery, "one of a kind," and we were not alone after all!

Rett syndrome is a neurological disorder which occurs only in young girls. It was first described in 1965 by Dr. Andreas Rett, of Vienna, Austria. Because of the relatively small circulation of his first article, most physicians were unaware of the disorder until a review of the syndrome by Dr. Bengt Hagberg from Sweden and colleagues from France and Portugal was printed in late 1983 in a widely read English language neurology journal. Further clinical documentation and new biochemical, physiological, and genetic data were presented at a conference on Rett syndrome held in Vienna in September 1984.

In January 1985, Dr. Rett visited the John F. Kennedy Institute for Handicapped Children in Baltimore, Maryland, for the first conference held in the United States. While there, he examined 42 girls who had been diagnosed as potentially having Rett syndrome. Subsequently, there has been a second conference taking place in November 1985, at which time 70 Rett syndrome girls were examined. These meetings have led to an increased awareness of the syndrome and its manifestations in the United States. Greater familiarity with the syndrome has resulted in better diagnosis.

While Dr. Rett was the first to describe Rett syndrome, the disorder was recognized independently in other parts of the world. Interest in the syndrome and knowledge about it are increasing at a rapid rate. As of this writing, the medical literature contains case reports from Austria, France, Portugal, Japan, Scotland, the United States, and Sweden. Currently, 300 cases have been diagnosed in the United States. In a prevalence study done in Sweden, the incidence of Rett syndrome was found to be 1:15,000 female births, accounting for one-quarter of all severe mental retardation in girls. This incidence is at least as common, if not more so, than PKU (phynelketonuria), for which every newborn in the United States is tested. Based on the Swedish prevalence study, there is a high probability that there are as many as 8,000 potential cases of Rett syndrome in the United States that have thus far gone undiagnosed. Out of 4,000 described genetic syndromes, Rett syndrome is one of only four involving only females.

Girls afflicted with the syndrome appear normal until six to eighteen months of age, then appear to arrest in development or regress in previously acquired skills. They exhibit the autistic features of withdrawal and isolation in the early stages of the disease, but these features improve with age. In about two-thirds of the children, seizures develop. Deterioration of higher brain functions leads to severe retardation, and the girls experience a slowing of head growth. The children lose the purposeful use of their hands and replace it with a stereotyped "hand-washing" movement in front of the face or chest, which may be constant. The children who walk do so with a broad-based gait. They often exhibit shakiness of the limbs and torso, grinding of the teeth, and grimacing of facial features. With ensuing years, the symptoms include spasticity, curvature of the spine, poor circulation in the legs and loss of walking mobility, if developed by that time.

Public and professional awareness of Rett syndrome must be a priority. Without the knowledge that this syndrome exists, physicians fail to diagnose this clinical picture as an entity. Without the diagnosis, there can be no direction. With an awareness emphasis, the possibility of diagnosing 8,000 cases in America is a realistic one.

To date, laboratory investigations have not revealed a cause for Rett syndrome, but there is a suggestion that as the syndrome is confined to girls, this may indicate a genetic basis involving one of the X chromosomes.

The need for finding a biological marker cannot be emphasized enough. Now, the diagnosis of Rett syndrome is purely a clinical observation and an evaluation of the medical life history of the child. One must dream of not only finding a biological marker on existing cases, but then applying the findings to neonatal, and perhaps prenatal situations, leading to earlier and earlier recognition of the presence of this illness. As in most cases, it is hoped that the earlier Rett syndrome is detected, the better the chance of the child to receive the benefits of intervention when and if treatment is discovered. I cannot stress enough that Rett syndrome girls develop normally until 6 to 18 months of age! By identifying the cause, determining a biological marker, and testing all newborn females there is a significant possibility of treatment, affording baby girls testing positive for Rett syndrome a normal life.

With respect to therapeutic intervention, the need for applied research, whether it be medical or educational, is extremely important for all Rett syndrome girls. Research data of education programs and specialized therapy techniquies are desperately needed to tap into what knowledge seems to lie behind the brightness of their eyes and to maintain physical use of their bodies.

More research is needed in all areas to give further insight into the syndrome. Research funding needs must be met, not only in print, but in actuality.

The International Rett Syndrome Association was incorporated in January 1985 as a non-profit organization for parents, interested professionals, and others concerned with Rett syndrome. The aims of the organization are to offer parent support through contact with other parents, to promote an awareness of Rett syndrome to the public and professional communities by providing an information and referral service, and to encourage research aimed at finding the cause of Rett syndrome and methods for its prevention, control and cure.

Our organization is available to work with the NICHD and the NINCDS to lend support, data and information regarding Rett syndrome cases of which we have knowledge. We keep an up-to-date geographical index of all Rett syndrome patients known to us and their doctors, in the hope that this information will prove useful to further study.

For too long the recognition of this disease as a distinct entity has been hidden. We have lost 20 years of potential research knowledge and this has caused many, many families to be unnecessarily burdened trying to find a diagnosis. With Rett syndrome there is an evolutionary process of acceptance that takes place as symptoms of the child manifest. No parent is ever prepared to hear that their child has not only become handicapped, but that the disease is slowly progressive. The ramifications of what this might mean not only in terms of the child's life, but in the whole scope of the family's life thereafter are incomprehendible. Some families have coped and endured, some could not. The turmoil is not without great emotional and financial expense. Now is the time to find the answers to our long-held questions about our precious daughters' developmental disabilities.

I would like to close with a quote from Dr. Andreas Rett in a letter to me. "I still consider this affliction tragic if not dramatic. It still affects me deeply to see such a child. I still try to explain to the parents what might occur in the brain of the child. I still see the strangely beautiful eyes of the children and wonder what thoughts there might be behind that seemingly lonely and lost gaze. Still the syndrome remains a mysterious disease. Many parents from many countries show us their children often hoping for a miracle. A miracle that we cannot offer since there are also no miracles in medicine."

There may be little hope for my daughter, but perhaps for another's child, there will be a miracle someday.

Mr. Chairman and members of the Committee, thank you.

Suggestions for future research directions as stated at the Second International Conference on the Rett Syndrome, sponsored by the John F. Kennedy Institute and the International Rett Syndrome Association, on November 20 - 24, 1985:

- Genetic linkage studies of X chromosome (especially in available affected sisters)
- Neuropathological studies:
  a. Protocol developed for study of brain material
  b. Recommendation for fixing and freezing of brain material to allow cooperative studies
  c. At least two laboratories each should specialize in microscopic and biochemical studies
- Complete post-mortem studies to look at other organs and neuropeptides
- Neurotransmitter and neuropeptide studies (much interest expecially in dopamine - on PET scan studies, in spinal fluid and in brain material)
- Tissue bank: fibroblasts and lymphoblasts; utilizing laboratories with good track records for such studies
- Look for animal models
- Look at precipitating environmental factors
- Develop tools for early diagnosis, both clinical (screening battery in infants being developed in Sweden) and genetic
- Pool cases of "variants" (no agreed upon definition presently available)
- Therapeutic trials (use of ketogenic diet was reported in two cases) in pooled pilot studies with structured protocols

In addition, the International Rett Syndrome Association would like to make the following suggestions:

- That a cooperative effort be made to promote the awareness of Rett syndrome with the hope of uncovering as many cases as exists, thereby affording researchers with an even larger pool of patients
- Research data be collected on specific and beneficial education and therapy plans to help maintain, and possibly increase, the child's level of learning and physical abilities

WEDNESDAY, MAY 7, 1986.

NIDDKD

WITNESSES

JASON ROBERTS, IMMEDIATE PAST PRESIDENT, JUVENILE DIABETES FOUNDATION

AARON RICH

Mr. NATCHER. Our next witness is Mr. Jason Roberts, and Aaron Rich.

Mr. ROBERTS. I have my co-star with me. We have submitted our prepared statement for the committee. It says a lot of what we said over the last several years. You know it as well as I know it at this point.

We decided we would go off the cuff a little bit, as I like to do, and tell you how we are succeeding because of what you have done and how frightened we are that it will stop.

It is almost as if I can describe the snowball rolling down the hill. You have given us that snowball, and diabetes has made some great strides. We have made some great strides and you have offered us a lot of hope. That snowball is rolling at a pretty fast rate, and hopefully, you won't let it stop.

I brought with me Aaron Rich. Should we show them our bracelets, and tell them why we have to wear them? In case we have a reaction?

Mr. RICH. Yes. You don't really know what—or where you are, and you don't feel that good.

Mr. ROBERTS. Pretty tough. You don't even know your own name sometimes. We wear the bracelets so if we are laying on the street, and they pick us up, they will know we are in a diabetic reaction, so they can take us to the hospital.

What does it feel like when you get the shots every day?

Mr. RICH. It feels like, I have to have it every day.

Mr. ROBERTS. We have to have it if we want to come here next year, and talk to you again. You have offered us this hope, this promise, and to Aaron, you have offered him a future.

We want to keep it going, and as I told Congressman Early earlier, it is all up to you, it is not up to us anymore. We have nowhere else to go. We have made great strides. Aaron, go get your blood glucose monitor. We would like to show you what you have done for us.

Now, diabetics can monitor themselves at home, test their blood at home. We stick a pin in our hands, take a little strip and we put it in that machine, put the strip in here, with the blood on it, press this button and it tells us what our blood is, so we can keep ourselves in better health.

So we can stay healthy, monitor his blood, eliminate these reactions possibly and live a better life. This is what you did because of the money that NIH had that developed the blood glucose monitoring.

That is among several of the things. The beta cell implants, those are progressing. It is all working.

I met with some researchers last week. I implore upon you, don't let go. I know you are our supporters, and I want to see it continue.

Right, Aaron?

Mr. **Rich**. Right.

Mr. **Roberts**. Who is your favorite baseball player? Who is your favorite basketball player?

Mr. **Rich**. Patrick Ewing.

Mr. **Roberts**. Coming from Massachusetts, I had hoped he would be Larry Bird.

Gentlemen, we implore you, we urge you to continue the support so necessary for diabetes research, and so necessary to cure this damn disease. It affects 11,000,000 of your fellow Americans, and 2,000,000 that have to stick themselves twice a day to save a life. We are making progress.

We need the dollars to keep the momentum. Aaron and I, we beg you, and we know you won't let us down.

Mr. **Rich**. Thanks.

[The statement of Mr. Roberts follows:]

Juvenile Diabetes Foundation International 60 Madison Avenue, New York, New York 10010-1550, 212-889-7575

EXECUTIVE OFFICE

Testimony of the

JUVENILE DIABETES FOUNDATION

Presented by

Jason Roberts

Immediate Past President

before the

House Appropriations Committee

Regarding

FY 1987 Appropriations for the

National Institutes of Health,

Centers of Disease Control, and

Indian Health Service

May 7, 1986; 11:30 A.M.

Summary of Recommendations:

The Juvenile Diabetes Foundation International recommends that, for FY 1987, the National Institutes of Health be appropriated $6.079 billion (a 10.4% increase over the FY 1986 funding level). The National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) should be appropriated $503.7 million; the National Heart, Lung, and Blood Institute (NHLBI) - $950 million; the National Institute of Child Health and Human Development (NICHD) - $356 million; the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) - $479 million; the National Institute of Allergy and Infectious Diseases (NIAID) - $424 million; and the Division of Research Resources (DRR) - $338 million.

We also recommend that $7.5 million be appropriated for the Centers for Disease Control's State Diabetes Control Projects and that the Indian Health Services be appropriated $2.4 million to operate the Model Diabetes Care Program.

JDF INTERNATIONAL IS A TAX-EXEMPT NON-PROFIT ORGANIZATION

DIABETES RESEARCH: AT A TURNING POINT

The Juvenile Diabetes Foundation International (JDFI) appreciates this opportunity to present its views regarding FY 1987 appropriations for the National Institutes of Health (NIH) and other federal diabetes programs. JDFI is an international voluntary health organization of over 160 chapters throughout the United States and the world dedicated to furthering research in diabetes and improving the quality of life of the diabetic.

In 1984 JDFI testified of our "countdown" toward a cure for diabetes. Today, as the countdown draws closer toward its ultimate objective, we face a turning point in the battle against insulin-dependent diabetes. We can either take the path toward a cure for this dreaded disease or we can capitulate to the budgetary red-liners at the Office of Management and Budget (OMB), turning away from the important goal of curing diabetes. Such a retreat would serve as a victory for those who seek immediate savings in federal spending.

Although Congress has been faced with difficult budgetary decisions over the past several years, the members of this Committee have repeatedly stood their ground, protecting a biomedical research effort which is the envy of the world. Today, JDFI submits its appropriations request in the face of the gravest threat ever; the specter of the Gramm-Rudman balanced budget legislation haunts us all. The threat of across-the-board budget cuts, a policy approach which JDFI and many on this Committee opposed from the very outset, is ominous. But the effort to attain the budget targets embodied within the legislation, so as to avoid triggering automatic reductions, may be equally onerous.

Basic and clinical biomedical research holds the promise of a cure for diabetes and countless other diseases that kill and cripple millions of Americans annually, exacting a monumental toll in human suffering. Moreover, the costs associated with health care treatment and lost wages and productivity soar into the billions of dollars. Dedication of modest resources to finance science is an intelligent investment in the future health of the nation. But most importantly such a commitment reflects the compassion of those who establish public policy for individuals in the shadows of life -- the young and the sick.

Moreover, diabetes research is cost-effective. For example, an annual savings of $454 million in the national cost of care for the blind can be realized through the use of laser therapy in advanced cases of diabetic retinopathy. Multiple similar examples exist. At the same time, on the other side of the equation, the federal government spends over $400 million per year supporting diabetics on dialysis — two times the NIH allocation for diabetes research.

Thus, research not only improves the quality of life of the diabetic, it ultimately promotes containment of health care costs.

THE FEDERAL DIABETES PROGRAM

Over the past dozen years, the federal diabetes program has come into its own. We now have the momentum to develop a diabetes preventive, to mitigate many of the disease's devastating complications, and, hopefully, to attain a cure. Indeed, the mechanism for continuing the federal onslaught on diabetes is securely in place: research is conducted in virtually every NIH Institute. There are seven diabetes research and training centers and four diabetes endocrinology research centers in operation. The Diabetes Data Group and the Diabetes Information Clearinghouse are effectively performing the functions mandated by Congress. The National Diabetes Advisory Board (NDAB), a body of government officials, health care professionals, and consumer-advocates, including a number of JDFI members, provides a coordinated focus for the plethora of federal diabetes-related activities. In one of its functions, the NDAB periodically revises our "blueprint" for a cure, the Long Range Plan to Combat Diabetes.

THE ADVANCES IN DIABETES RESEARCH

Today we are at a turning point because of the efforts of this Committee over the past decade. The investment you have made has paid off in enormous dividends. We can now point to major successes in the treatment of this Nation's diabetics. Moreover, we now have a reasonable basis for being optimistic about a cure and the prevention of this insidious disorder. Consider, for example:

- Researchers have already successfully transplanted clusters of insulin-producing beta cells from one animal species to another. Scientists have demonstrated that beta cells from healthy rats transplanted into diabetic mice actually reverse the diabetes in mice. Now, clinical trials in pancreatic islet transplantation have been finally initiated on human subjects to test whether this procedure can, indeed "cure" diabetes.

- NIH-sponsored research has responded to the need for a better method to deliver insulin. Several alternatives, at various experimental stages, have been produced by this research: an insulin nasal spray, an insulin inhalant, micro-electronic computerized insulin pumps, and transplantation of insulin-producing beta cells.
- Diabetic blindness is devastating and widespread; moreover, it is perhaps the most feared diabetes-related complication. Now, due to the research sponsored at NIH, laser technology and new surgical procedures have reduced the incidence of new blindness among diabetics by as much as 60 percent.
- Diabetic pregnancies used to entail a much higher than normal risk of fetal death or congenital malformation. Now, through NIH sponsored research, we know that when blood sugars are normalized through tight control, a diabetic woman's risk of infant mortality falls to approximately the same level as the non-diabetic population.
- Recent NIH research is focusing on the action of an enzyme, aldose reductase which converts glucose into a form of alcohol called sorbitol. Concentration of sorbitol in the system, a condition which is common in diabetics, causes cell deterioration. Thus, in turn, results in loss of sight, kidney and nerve damage. Understanding this process has enabled scientists to develop drugs which block the enzyme and thus prevent the accumulation of sorbitol. These drugs are now being tested with positive results to retard damage to nerve tissue, as well as to resolve kidney and eye complications.

THE SCOPE OF DIABETES

Despite the cause for optimism in diabetes research, the specter of diabetes and its devastating complications defines the alternative path we approach at this turning point. Diabetes is the third leading cause of death in the United States; the leading cause of new blindness; the cause of 50% of foot and leg amputations among adults; the cause of severe neurological disorders; the cause of a disproportionately high rate of infant mortality, congenital malformations, respiratory distress, prematurity, and other serious medical problems; a major risk factor for cardiovascular disease; and the cause of 20% to 25% of kidney failure. Indeed, experts estimate that $15 million is sapped from the American economy per year in both the direct and indirect costs of this disease.

THE ADMINISTRATION'S FY 1987 BUDGET

Against this backdrop looms the Administration's proposed budget for FY 1987: a bleak and desolate path of retreat and retrenchment from a responsible health care policy. The elements of the President's biomedical research policy include proposed funding reductions in FY 1987, ill-advised "micromanagement" of the scientific programs at NIH, OMB-proposed reductions in direct and indirect costs of research grants, and rejection of major new initiatives in diabetes research and other areas of overwhelming scientific opportunity.

For FY 1987 the President recommends cutting NIH funding to $4.9 billion. This represents a 5% reduction from the actual FY 1986 level of funding and an unconscionable 10% reduction from the FY 1986 level as appropriated by Congress. These cuts would be achieved through paring back the number of new research awards to 5,104. NIH would face a significant reduction in numbers of research centers. Indirect costs would be reduced by $85 million through imposition of a cap.

This level of support would further: limit funding for high quality research by substantially reducing the payline for new and competing research grants; provide funding for only 27% of approved research grants; reduce the number of approved clinical trials thereby restricting the migration of new therapies "from bench to bedside"; exacerbate the deterioration of the physical plants and animal laboratories at institutions across the nation; freeze the number of research trainees despite a critical shortage of young clinical investigators; and reduce the number of full-time equivalent NIH employees.

We have spoken of the "investment" in biomedical research, and of the importance of "research and development" in every enterprise, private sector or governmental. These devastating reductions in NIH funding are all the more intolerable because the Administration has proposed a government-wide R&D average increase of approximately 17% which would augment the number of defense-related research scientists from 5,000 to 18,000. It is insidiously ironic that, concurrently, we will lose many of the bright young clinical investigators who may cure diabetes, heart disease, cancer, and other major health problems in the years ahead.

We are also concerned with OMB's increased involvement in the management of NIH affairs. As of August 1985, OMB instituted a new mechanism for apportioning funds within NIH thereby expanding the control of bureaucrats over the number and size of awards and the allocation of funds among program mechanisms, such as clinical trials, centers, population studies, research career and training awards and developmental contracts. It is imperative that Institute Directors and NIH Advisory Councils be afforded ample flexibility to identify and provide appropriate support for initiatives embodying scientific merit.

JDFI FUNDING RECOMMENDATIONS FOR NIH

Today we face a major choice. As we approach the major turning point in biomedical research into diabetes, Juvenile Diabetes Foundation International recommends that Congress appropriate $6.079 billion for NIH in FY 1987. This request, as allocated on the table of recommendations appended to this testimony, represents a 10.4% increase in the NIH budget.

For the most part, our proposed budget would simply maintain current services at the levels provided by Congress in the FY 1986 appropriations bill. New and competing research grants would be funded at a priority score of about 165-170 with 33% of approved applications receiving support. Funding at these levels would allow for modest growth in research career awards and would permit raising the current level of research trainees to that recommended by the National Academy of Sciences (NAS). This proposal permits needed upgrading of primate centers and research laboratories. A funding level of $6 billion provides additional monies for General Clinical Research Centers (GCRCs) to facilitate the conduct of research projects and trials. Finally, at this level of support, a slight increase in the number of research centers is insured.

National Institute Of Diabetes, Digestive and Kidney Diseases (NIDDK)

Within this increase, we recommend that, for FY 1987, Congress specifically allocate $503 million to the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK), the cornerstone of the federal diabetes research effort. Under the Administration's budget request fully 11% fewer new research grants would be funded in FY 1987 than were supported in FY 1986.

A $503 million budget for NIDDK would restore cutbacks in research grants, traineeships, career awards, and intramural programs. Full indirect and direct costs would be paid for 637 new and competing research grants, thus maintaining the current fiscal year's level of support. Our recommended budget would permit the funding of about 33% of all approved research grants, a rate consistent with recent years' appropriations. It is also necessary to provide ample funds to pay for grants at study section-approved levels. Enactment of the Administration's budget would result in further downward negotiations in grant payments, thereby jeopardizing the scientific integrity of these projects. Moreover, any reductions in direct and indirect funding should reflect an overall agreement between Congress, the research community, and NIH.

Under the Administration's budget, many major diabetes initiatives would be eschewed. At our proposed funding level of $503 million, the Institute would be able to reconsider supporting the following initiatives: a new transplantation initiative; an expansion of support for the procurement and distribution of tissue for research; an increase in the number of diabetes/endocrinology centers; and reinstatement of nephrology and neurological components within the Diabetes Control and Complications Trial.

The NIH Reauthorization legislation, adopted in 1985, authorized the creation of an arthritis institute out of the existing National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases (NIADDK). The cost of establishing the new arthritis institute has been set at $3.5 million. Thirty-six new staff positions would be required. These additional resources have not yet been provided. The diabetes program of NIDDK will be severely hampered and the intent of Congress will be thwarted if the necessary resources are not immediately forthcoming. Under no circumstances should the funds allocable to the residual institute for research or administrative programs be diverted to support the new NIAMS.

National Heart, Lung, and Blood Institute (NHLBI)

Under the superb leadership of Dr. Claude Lenfant, the NHLBI has continued to offer enormous support for diabetes research. The high level of visability for diabetes within NHLBI reflects the fact that diabetes is one of the four major risk factors of cardiovascular disease, including stroke, arteriosclerosis, and coronary heart disease. JDFI believes that $950 million should be appropriated to NHLBI so that it can expand its diabetes research program and maintain an effective and programmatically balanced heart, lung, and blood initiative.

National Eye Institute (NEI)

As discussed above, diabetes is the leading cause of new blindness in the United States; its costs in terms of health dollars, lost productivity, and human pain and suffering are momentous. The National Diabetes Advisory Board has identified several priority areas for ocular research which can continue to be implemented if Congress appropriates $216 million to the National Eye Institute.

National Institute of Neurological and Communicative Disorders and Stroke (NINCDS)

While there are exciting diabetes initiatives being supported throughout NIH, there are a few examples of totally inadequate commitment to diabetes research, most notably, the National Institute of Neurological and Communicative Disorders and Stroke. We are disturbed by NINCDS' continued lack of interest in supporting research in the area of diabetic neuropathy, a devastating complication of diabetes. The Institute's lack of responsiveness is exemplified by its withdrawal from the Diabetes Control and Complications Trial (DCT) and its failure to establish research or training initiatives designed to promote interest in the area. We respectfully recommend that $479 million be appropriated to NINCDS and that the Institute be directed to expand its research into the neurological complications of diabetes.

CENTERS FOR DISEASE CONTROL (CDC)

CDC has spearheaded a number of very significant programs designed to implement the Long Range Plan to Combat Diabetes. Despite this success story the President's budget would eliminate funding for this program altogether. JDFI recommends that Congress appropriate $7.5 million for CDC's National Diabetes Control Program in FY 1987.

INDIAN HEALTH SERVICE (IHS)

Diabetes is a critical health problem among American Indians, affecting almost 50% of adults in some tribes. Several years ago, Congress authorized a Model Diabetes Health Care Program to develop and evaluate effective and culturally acceptable methods to reduce the severity of the disease. Legislation has recently been introduced to expand this program. Consistent with this direction and with the need to accelerate the transfer of effective diabetes control strategies to other units within the IHS service population, JDFI recommends that Congress provide $2.4 million in FY 1987 for this program.

CONCLUSION

We have come a long way in diabetes research -- over a dozen research breakthroughs in just a few years. While estimates place the social and health care costs of diabetes as high as $15 billion, Congress can make the sound investment choice to increase funding for the federal diabetes research effort. We want nothing more than to put JDFI out of business, and the federal diabetes research initiative as well. But the bottom line is: Have our children been cured?

We pray that the Members of this Committee, will maintain their vision, ignoring what may be politically expedient. Our hope is that you will continue to do what you know in your hearts is right. In this way we will achieve our goal — biomedical research will continue to thrive and the high road will be taken.

JUVENILE DIABETES FOUNDATION: FY 1986 APPROPRIATIONS RECOMMENDATIONS[1]

in millions of $

NATIONAL INSTITUTES OF HEALTH	FY 1986[2] Approp.	Diabetes Dollars In FY 1986	AFTER GRAMM-RUDMAN FY 1986 CUT[3]	ADMIN. FY 1987	JDF Recommendation	Diabetes Dollars Under JDF Rec.
National Institute of Diabetes, Digestive and Kidney Diseases	456.1	(109.5)	436.1	419.0	503.7	(124.0)
National Heart, Lung, and Blood Institute	859.9	(20.5)	811.5	785.7	949.6	(24.0)
National Eye Institute	195.2	(23.2)	186.6	179.2	215.6	(26.0)
National Institute of Child Health and Human Development	322.3	(11.9)	308.2	309.1	355.9	(13.0)
National Institute of Neurological and Communicative Disorders and Stroke	423.4	(4.7)	413.0	399.4	478.6	(6.5)
National Institute of Allergy and Infectious Diseases	384.0	(5.9)	341.4	330.6	424.1	(8.0)
National Institute of Aging	157.8	(2.2)	150.9	145.0	174.3	(2.2)
National Institute of Dental Research	103.4	(4.9)	98.2	96.5	114.2	(5.0)
National Institute of General Medical Sciences	516.0	(1.1)	493.6	471.5	569.7	(1.2)
National Institute of Environmental Health Sciences	197.5	(.3)	188.9	188.0	218.1	(.5)
National Institute of Arthritis, Musculoskeletal and Skin Diseases	116.5		111.3	106.7	128.1	
National Cancer Institute	1,256.5		1,174.3	1,158.1	1,387.6	
Division of Research Resources	305.7	(15.5)	290.8	234.2	337.6	(17.0)
National Library of Medicine	57.8		55.3	56.4	63.8	
John E. Fogarty International Center	11.6		10.9	11.3	12.8	
Office of the Director	117.0		45.0	36.7	129.2	
Buildings and Facilities	14.9		14.3	8.0	16.5	
TOTAL NIH	5,505.2	(199.7)	5,130.3	4,936.2	6,079.4	(227.4)

[1] Figures in columns may not foot because of rounding.
[2] FY 1986 Appropriations Figures Include FY 1985 Carryover.
[3] All reductions reflect across-the-board cut of 4.3 percent.

* * *

Centers for Disease Control Diabetes Control Project	5.0	(5.0)	4.8	0.0	7.5	(7.5)
Indian Health Service Model Diabetes Care Program	1.9	(1.9)	1.8	1.8	2.4	(2.4)

Mr. NATCHER. Thank you very much, Mr. Roberts. You have given us an an excellent statement. Aaron, you take care of yourself, and come back and see us.

Mr. ROBERTS. He is going to be my replacement.

Mr. CONTE. Where is Aaron from?

Mr. ROBERTS. From Washington.

Mr. CONTE. I thought he was from Massachusetts.

Mr. ROBERTS. No, I am from Massachusetts.

Mr. CONTE. I was worried, because I thought he was going to run against me.

Mr. EARLY. Mr. Chairman, might I say, Aaron, if you do replace Mr. Roberts, and you are here many years, Mr. Natcher and Mr. Conte will still be here.

Mr. NATCHER. All right. Thank you very much. Thank you, Mr. Early.

WEDNESDAY, MAY 7, 1986.

FEDERAL MEDIATION AND CONCILIATION SERVICE

WITNESS

HON. STAN LUNDINE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. NATCHER. Our next witness is our friend and colleague in the House from New York, Mr. Stan Lundine. Come around, Mr. Lundine, we will be pleased to hear from you.

Mr. LUNDINE. Thank you very much, Mr. Chairman. I would ask unanimous consent my entire statement be made a part of the record.

Mr. Chairman, I appreciate this opportunity to appear before the subcommittee and talk to you on the subject of the appropriations for the Federal Mediation and Conciliation Service, for their work in support of labor-management committees.

It is my belief that the funding provided under the Labor-Management Cooperation Act in 1978 is one of the most cost-effective and worthwhile investments in our economy that we can possibly make.

The aim of labor-management committees is to bridge the adversarial relationship between workers and management, to improve productivity, and to encourage local economic development.

Often, these committees can make a difference in the attraction of new businesses to a community, preventing plants from closing, and helping faltering industries to remain alive.

They have great experience in bringing workers and employers together to work out their differences, that benefit not only labor and management, but the entire community.

As you know, Mr. Chairman, my experience with this goes back to when I was the Mayor of Jamestown, New York, and we started a labor-management committee there. Within three years, our unemployment rate went from 10.2 percent to 4.2 percent, primarily with that committee serving as a catalyst, to bring labor and management together to improve productivity, and to attract new industry and solve other problems such as worker training.

That committee continues today. We believe that Jamestown has a much healthier economy, that literally millions of dollars in unemployment compensation and other benefits have been saved in our community alone, because of some Federal seed money. It was $22,000 of Federal grant support that got that committee started, and we then served as a model for other area-wide committees.

This year, I visited Cumberland, Maryland, in the western part of the State, celebrating their 10th anniversary of the Cumberland Area Labor-Management Committee in Maryland. They believe, as we do in Jamestown, that labor-management committees have a tremendous impact in improving productivity, and the quality of working life for employees, in upgrading the skills of existing employees and in providing new employment opportunity for other people.

It is not just a few small communities. The Federal Mediation and Conciliation Service grants have served large cities and small alike. They go to specific industry committees.

This last year, for example, FMCS received 70 grant applications requesting over $5,200,000 in funds, and 16 were funded, including the National Steel Corporation in Pittsburgh, which saved the jobs of many steelworkers there, public sector committees in St. Paul, Albany, Fresno and Missoula, Montana, and area committees in Ohio, Kentucky and Alabama, to name a few.

The success of the labor-management committee program is not just in turning bad labor situations into good ones, it is cost-effective in that it enhances America's competitiveness, in an increasingly intense worldwide economy.

We authorized the program for $10,000,000, and the peak of funding was 1,200,000 in 1981. I personally believe the program should be funded at a much higher level. At the very least, we must preserve the current funding level if we are to have any functioning program.

It makes no sense to pay high prices for losses in unemployment benefits, productivity losses and the many ripple effects of plant closings when many of these costs can be avoided with relatively low cost assistance to labor-management committees in troubled areas.

In an era of fiscal restraint, and I fully appreciate the problem that this subcommittee is up against appropriating as much money as any other in the Congress and against very severe limits, in this kind of an era, there is no better investment than in this labor-management program, and I urge your continued support for this worthwhile program.

Thank you very much.

Mr. **Natcher**. Thank you very much, Mr. Lundine. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Mr. Lundine follows:]

Congressman Stan Lundine

Testimony before the

Subcommittee on Labor-Health and Human Services-Education

of the House Committee on Appropriations

May 7, 1986

Thank you, Mr. Chairman. I appreciate the opportunity to speak to you today on the subject of appropriations for the Federal Mediation and Conciliation Service (FMCS) for their work in support of labor-management committees. It is my belief that the funding provided under the Labor-Management Cooperation Act of 1978 is one of the most cost-effective and worthwhile investments in our economy that we can make.

The aim of labor-management committees is to bridge the adversarial relationship between workers and management, to improve productivity and to encourage local economic development. Often, these committees can make the difference between a productive town that is attractive to new businesses and successful in preventing plants from closing, and a faltering industry town with high unemployment and low worker morale. Labor-management committees bring employers and their workers together to work out their differences in positive ways that benefit not only labor and not only management, but the entire community.

As many of you know, my initial experience with labor-management cooperation came when I was mayor of Jamestown, New York, a small manufacturing town in upstate New York. Jamestown in 1972 had many of the problems that communities across the nation are experiencing today. Businesses were closing, unemployment was soaring and the adversarial relationship between government, business, and labor was the principal underlying cause for the community's dismal economic outlook.

In this crisis atmosphere and through a lot of hard work from many dedicated people, local government, management and labor replaced their adversarial relationship with one of mutual trust and respect and worked together to turn the local economy around. The labor-management cooperation which took hold in Jamestown, and still exists today, succeeded in improving productivity, the quality of worklife, and the use of human resources in individual workplaces.

Jamestown is not unique in the success it experienced with labor-management cooperation. Since the Labor-Management Cooperation Act was passed in 1978, hundreds of labor-management committees have been established throughout the United States. By improving relations in the workplace and by involving employees in workplace decision-making, these committees have had the effect of increasing productivity and product quality, improving employee satisfaction and improving job security as well. Industry has been retained, jobs have been saved and new businesses have been attracted to these previously troubled areas.

Labor-management success stories can be found throughout the country. These committees have been successful in individual plants, on an area-wide basis, in the railroad and construction industries, as well as a remedy for public sector labor problems.

The importance of federal seed money to these efforts cannot be stressed enough. The very nature of labor-management problems makes third party intervention essential for two primary reasons. First, to be effective, mutual trust is critical. Providing the committees with an outside, neutral source of financial and technical assistance prevents any perception of the effort as being preponderantly labor or management oriented. Second, there is often the need for technical advice and research that some areas simply are not able to afford. The seed money is absolutely essential in starting the labor-management cooperation efforts. It is a testament to the value and success of labor-management committees that most communities decide to continue funding the committees in their area once the federal seed money is no longer available.

In 1985, FMCS received 70 grant applications requesting over $5.2 million in funds. This was the largest number of applications received and serves as proof that the need of support for cooperative efforts continues to grow. Sixteen applications were funded including support for worksite committees by National Steel Corporation in Pittsburgh, public sector committees in St. Paul, Albany, Fresno and Missoula and area committees in Ohio, Illinois, Kentucky, and Alabama to name a few.

With all that has been said about the success of labor-management committees and their worth in turning bad labor and industry situations into good ones, it is amazing that the level of funding for this program has been so low. While the program is authorized at the level of $10 million, funding peaked at $1.2 million in 1981 and has remained at $1 million for the last couple years.

I believe the program should be funded at a much higher level. At the very least, we must preserve the current funding level if we are to have a functioning program. It makes no sense to be paying high prices for losses in unemployment benefits, productivity losses, and the many ripple effects of plant closings when many of these costs can be avoided with relatively low-cost assistance to labor-management committees in troubled areas. In an era of fiscal constraint, there is no better investment and I urge your continued support for this very worthwhile program. Thank you very much.

WEDNESDAY, MAY 7, 1986.

NATIONAL CANCER INSTITUTE

WITNESS

ALAN C. DAVIS, VICE PRESIDENT FOR GOVERNMENT RELATIONS AND SCIENCE EDITOR, AMERICAN CANCER SOCIETY

Mr. NATCHER. Our next witness is Dr. Alan Davis. We are glad to have you back before the committee this morning.

Mr. DAVIS. I must say, as an aside, after the very touching and dramatic presentations regarding Rett syndrome, juvenile diabetes, although I have an extremely important message, I was deeply touched by those witnesses.

Mr. Chairman, members of the committee, I thank you for this opportunity on a matter of highest priority for all Americans. My name is Alan Davis, Vice President for Government Relations and Science Editor of the American Cancer Society.

With more than 2,500,000 active volunteers across the Nation, I appear before you as a representative of the world's largest voluntary health coalition, and I am honored to pinch hit for our National President, Dr. Charles Le Mastre from Houston, Texas, who is unable to be with us.

Each year, the American Cancer Society recommends to Congress a "Citizen's Budget" figure for the National Cancer Institute. This figure represents the reasoned judgment of the Society about the portion of our national resources that is needed to sustain the rapid progress we are making against cancer.

I have submitted for the record a detailed statement in support of the NCI budget appropriation. In the interest of time, however, I would like to devote the next few minutes to discussing recent progress against cancer. That progress has been so great, and the time today is so short, that I can not do justice to the tremendous strides we have witnessed in recent years.

Those strides have been made possible by an explosion in knowledge from biomedical research, knowledge we have gained since the passage of the landmark National Cancer Act of 1971.

Let me be more specific: Many of those advances have, in fact, come about only because of the support American scientists have received under terms of that Act. For each dollar invested in cancer research in the last 15 years, we have earned a dividend of enormous proportion.

We must remember that cancer is a disease as old as man's recorded history. Down through all those ages, cancer has dominated its relationship with man, until just recently. In less than two decades, we have learned more about cancer than in all the centuries that have come before.

As a result of that knowledge, cancer has been transformed into a highly curable chronic disease.

Today, nearly half of all the once-deadly cancers can be cured. The one-half that cannot be cured are better controlled with longer survival and a much higher quality of life for those patients.

The American Cancer Society cites at least 14 forms of cancer that had a very poor prognosis only two decades ago. Now, each is largely curable. We have achieved remarkable progress in the treatment of many childhood cancers—the leukemias, bone cancer, kidney tumors—all have yielded to advances in treatment.

In adults, Hodgkin's lymphoma, testicular cancer, cervical cancer and some less common cancers, all have given way to effective therapy. And many other forms of cancers can be cured, if they are found and treated before they have spread throughout the body.

My message this morning is plain. We have come too far to turn back now. And your leadership, Mr. Chairman, together with the tremendous cooperation you receive from Congressmen Conte, Porter, Early and the other members of your committee, has brought us to where we are.

The Congress has provided the resources in the past that have made this dramatic progress possible. History will record whether we slow the momentum or finish the job.

If the rate of progress continues that we have enjoyed for the last 15 years, then cancer is certain to be eliminated as a major health threat in society.

In the past few years, we have learned a great deal through basic research about the path that leads the normal cell to become a cancerous one. Yet our knowledge is far from complete.

We have made great progress in improving the effectiveness of cancer surgery, radiotherapy and chemotherapy. Yet we must do more to reduce the trauma and side-effects of therapy and increase its effectiveness.

We have introduced an exciting new method of treatment, immunotherapy to stimulate the body to fight its own disease. But we must pursue this further to identify its true place in the successful treatment of cancer.

We know more than ever about how to prevent cancer. But we still must add a caveat and say "theoretically," because not all the mechanisms of cancer causation are fully understood.

I conclude by reminding you that cancer remains the second leading cause of death in the United States, despite amazing progress in prevention and treatment. The war on cancer needs to be continued on an all-out basis, even in the face of many demands for our limited national resources. The Federal research support that produced the achievements of today needs to be sustained and strengthened.

Against this backdrop, I appear before you today on behalf of the American Cancer Society, to urge an NCI appropriation of $1,322,000,000 in fiscal year 1987, a level that is vital to assuring continued progress against cancer.

I also call your attention to the new "apportionment" process imposed on the National Institutes of Health. Each Institute needs a degree of flexibility, to quickly take advantage of research opportunities that may arise during the year, but cannot always be anticipated.

To provide that flexibility, we recommend that language be included in the appropriation bills to permit each Institute to apportion its own resources to best address its mandated goals.

The achievements of the past few years are but prologue for even greater accomplishment on the immediate horizon. American men and women of science and medicine have the determination, the momentum and the creativity to complete the hard-fought battle against cancer. But they need the resources in order to do so.

I thank you for this opportunity and would be pleased to answer your questions.

[The statement of Mr. Davis follows:]

AMERICAN
CANCER
SOCIETY®

TESTIMONY OF

ALAN C. DAVIS

VICE PRESIDENT FOR
GOVERNMENT RELATIONS

AND

SCIENCE EDITOR

AMERICAN CANCER SOCIETY

ON THE FY '87 APPROPRIATION
FOR THE NATIONAL CANCER INSTITUTE

BEFORE THE
SUBCOMMITTEE ON LABOR,
HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

MAY 7, 1986

Mr. Chairman and members of the Committee, I am pleased to be here today to present the "Citizen's Cancer Budget" on behalf of the American Cancer Society, the World's largest voluntary health agency with over two and a half million active volunteers.

I am Alan C. Davis. I am Vice President for Government Relations and Science Editor of the American Cancer Society.

Mr. Chairman, each year the American Cancer Society recommends a "Citizen's Budget" figure for the National Cancer Institute to the Congress. Traditionally, this figure has represented the judgement of the Society regarding that portion of the national resources which the U.S. Government should dedicate to the battle against cancer. Also, traditionally, the Society's figure has been considerably higher than that recommended by the President in his annual Budget Message.

While the Society's recommendation has been higher, it has in every instance, represented the Society's attempt to be practical and responsible, while at the same time, cognizant of what funds are necessary to fight cancer.

The national economic situation required a scaling back in 1985. Last year, the Society's position was that while the need for a national investment in NCI of $1.5 billion was fully justified, the Society was recommending an appropriation of $1.3 billion, and asking the scientific community to roll up their sleeves, emphasize economies, do more with less, and make up the remaining $200 million in productivity gains, deferral of major purchases, and other means, to bring the total FY 1986 national investment in cancer research to $1.5 billion.

Congress responded by appropriating $1.258 billion -- nearly $100 million over the previous year, and almost to the ACS recommended figure of $1.3 billion. We especially applaud and commend this Committee, Mr. Chairman, and particularly your leadership, for appropriating that additional $100 million.

FY 1987 poses a fiscal problem more severe than any previously faced by the government. The federal deficit is higher than it has ever been. Congress, in an attempt to gain a measure of control over runaway deficits, passed the Gramm-Rudman-Hollings bill requiring a balanced budget by 1990; to be accomplished by deep, across-the-board budget cuts each year, from now until balance is reached.

With rare exception, no government program will be spared the effects of Gramm-Rudman-Hollings. The National Cancer Institute has already lost $54 million in the first round of Gramm-Rudman-Hollings budget cuts. Thus, the NCI budget for FY '86 has been reduced from the original $1.258 billion to $1.202 billion. This will result in numerous significant cuts in NCI's program including: loss of federal funding for five Comprehensive Cancer Centers and five organ site programs -- with marginal funding for the remaining centers and organ site programs; loss of some vital clinical cooperative groups; and severe cuts in the Cancer Communications Program, among others. Research grants could be reduced across-the-board. Severe loss of the momentum in progress against cancer through research, prevention, and treatment that is so vital to a dynamic program, will result.

Mr. Chairman, cancer does not recognize or acknowledge the problems that government has with its finances. Cancer knows no boundaries. It is apolitical. It will continue cutting its inexorable swathe through the lives and means of Americans regardless of Medicare cuts, defense appropriations, or Gramm-Rudman-Hollings.

With the American people, cancer is the top health priority. Every year the American people renew their expression of this priority through significant increases in their support of the American Cancer Society's programs of research, support, education, and service. The Society carries out its programs with no funds of any kind from government, and, because of this, is in a unique position among private sector organizations to speak with independence and objectivity on national cancer research and treatment support needs.

The American Cancer Society does not believe that the National Cancer Institute budget should be cut. The Society calls for increasing the NCI appropriation to $1.322 billion in fiscal year 1987. The American Cancer Society believes that the small, proposed increase would serve to maintain the level of momentum vital to assuring continued progress against this disease.

The dynamic progress against cancer cannot survive abrupt reductions, program cancellations, and across-the-board disruptions in personnel. Cancer has no respect for man's other problems, and continues to drain energies and resources of our nation and its people to the tune of approximately $40 billion a year in lost wages, jobs and medical costs.

But while our nation has great difficulty containing the annual $40 billion leak in our national economic dike that is represented by the cost of cancer, individuals and organizations like the American Cancer Society have to act responsibly. It is incumbent on us to do our part in sharing solutions, as well as responsibility for the cause of our current fiscal problems. For this reason, the Society is asking only for a minimal increase in the NCI appropriation, to "mark time", until the current fiscal crisis is relieved. We believe that the simple cost of living increase we recommend would serve to carry the National Cancer Program through this crucial period in our nation's economic history.

We sincerely believe, Mr. Chairman, that the funds that this Committee has appropriated during the past 15 years to the National Cancer Institute, represent the most productive health and medical research investment our nation has ever made in terms of real returns for our citizens. In the short span of those few years, more progress has been made against cancer -- man's most complex and determined health and medical enemy -- than in all of previous history. You, and your committee have literally made history through the wisdom of your decisions about funding of cancer research.

I say this in the context of recommendations, which we believe to be unwise, which have been made to reduce the NCI appropriation for 1987. We do not minimize the importance of deficit reduction. However, in considering the appropriation for cancer research, we urge you to consider the tremendous fiscal consequences of disrupting the cancer program. As I stated earlier, cancer costs this nation $40 billion every year. That cost is a significant factor in the national deficit. It will not be reduced if we lessen our efforts in fighting cancer. On the contrary, we will reduce and eliminate the cost only by capitalizing on the breakthroughs made as a result of the investments in cancer research over the past fifteen years. Let me assure you, Mr. Chairman, that the breakthroughs that we are seeing now are historic. We can not afford to lose momentum now.

I would like to cite a few of these returns which have helped bring the number of lives saved from cancer from one in three, just a few years ago, to one in two today.

To really appreciate and understand the phenomenon of progress against cancer, it is important to accept the fact that cancer is a basic biological process. There are billions of cells in the human organism. Every one of them has a control mechanism dictating when it will divide, how frequently, when it will stop, or start division. At some point, for a variety of reasons: heredity, influence of carcinogens, lifestyle, environment, aging, some cells lose their ability to reproduce in their normal programmed way. This loss of control becomes cancer. Therefore, one might say that understanding cancer and its process is to understand life, and its process. It is a tall order, but significant inroads are being made. The genius of man is slowly, but decisively stripping away the mystery of those phenomena through research, and the fruits of that research are represented in the design of new ways to attack the disease, with increasing success.

Research is yielding vital knowledge of the basic biological process. Dr. DeVita described the most dramatic developments to you in his exciting testimony several weeks ago. I would like to reiterate some of the more important things he told you.

Based on new knowledge of cancer biology, major efforts are under way to prevent cancer; to reverse the cancer process by nudging a transformed cell back to normal; to employ the exquisite network of our immune system to defend against cancer; to refine treatment and destroy more selectively cancer cells; and to block metastasis -- the ability of cancer cells to spread and kill. The investment in basic research made possible by the National Cancer Program has led us today to an unprecedented understanding of the cancer cell.

As we know, chemotherapy kills cancer cells. Unfortunately, it often is a very unpleasant treatment for the cancer patient, because while killing cancer cells, it also subjects healthy cells to its damaging impact. Fortunately, the prospect for cure outweighs the trauma of the treatment in most people. One of the problems with this effective, but sometimes unpredictable form of treatment is resistance of the cancer cell to the chemotherapy. It has been learned that such resistance can be caused by exposure to some environmental toxins. A recent, and important advance is represented in a new conceptual unity that now connects such distant events as drug resistance in advanced cancers with the same fundamental mechanism of cancer transformation itself. It is now apparent that a common set of genes controls enzyme systems that resist the carcinogenic effects of environmental toxins and help prevent cancer in animals and humans. The ultimate failure of this process is followed by the loss of control of the switches that regulate growth, leading to malignancy. However, it is now known that cancer cells retain these defenses in some capacity and are able to resist the very chemicals used to treat them. Now this information can be used on a practical level since modification of these resistance genes could improve treatment with drugs with potentially startling simplicity.

While cancer cells exert lethal effects by growing out of control, they appear to be immature, somewhat confused cells, aberrantly using the same genetic mechanisms established for normal growth and development. New biology has allowed researchers to tap into this genetic machinery at the heart of the cell and find minute, but critical, differences in genes of normal and cancer cells. They discovered oncogenes involved in transforming healthy cells into cancer cells. The counterparts of these genes, proto-oncogenes, are involved in normal growth and development. It has long been thought that cancer is a multistage process with intricate circuits and switches, working at different points of disease progression and at different times. Some substances serve as initiators that start but cannot finish the cancer-causing process without the help of promoters. Most promoters cannot work in cells that have not been initiated. With new technology, it is possible to study the genetic switches which trip the sequence of events that control growth and development or lead to cancer. Although cancer is over 100 different diseases, scientists feel certain they share some basic mechanisms that set off the disease. Understanding this has already led to the use of this data at the clinical level.

Reducing the incidence of cancer is one of our major goals. One of the best hopes for accomplishing this in our lifetime is controlling the effect of cancer "promoters" in people who are exposed to cancer "initiators". Real progress has been made in efforts to interfere with promotion. For example, curtailing wide use in the 1970's of the "promoter" estrogen used for menopausal symptoms, led to a dramatic, rapid reduction in uterine cancer. Cigarette smoke contains both initiators and promoters, but the removal of the promoters' effect may be the key event in avoiding lung cancer. This year NCI reported that the incidence of lung cancer in white men has decreased significantly for the first time in at least 50 years. This provides evidence that the exposure to chemical initiators in cigarette smoke does not irreversibly destine a person to develop cancer and that people can reduce their cancer risk by interrupting the carcinogenic process at its later stages by quitting smoking.

These are just a few of the exciting developments in understanding cancer that have come out as a result of the great support of this Committee to the National Cancer programs. I commend Dr. DeVita's exciting testimony to you for further elaboration.

I call particular attention to the new "apportionment" process imposed on the NCI and other NIH institutes. We believe that language should be included in the appropriation bills that would allow NCI, and other institutes, to apportion their reduced resources in the way that the leadership of these agencies believe is the best for their programs and their objectives.

Mr. Chairman, we at the American Cancer Society understand our Nation's fiscal dilemma. We do not envy your role in tiptoeing through the deficit reduction mine field on your way to allocating our limited national resources to real needs, such as the cancer program. But we do believe that you have the power and authority to prevent unwise applications of cost cutting measures.

Mr. NATCHER. Dr. Davis, you have made an excellent statement. We appreciate your appearance before the committee.

Doctor, all down through the years, we on this subcommittee and on the full Committee on Appropriations are right proud of the progress that we made in a number of categories and fields as far as health and education is concerned.

I recall, Doctor, when I was first elected a member of this committee, we had $71,000,000 for NIH. Now we are up to about $5,500,000,000, and that is the way it should be. It should be 10,000,000,000.

Dr. DAVIS. Sir, you are right, and this is certainly one of the more dynamic and constructive and productive committees of the Congress, and we are most grateful to you, sir, particularly, and to your colleagues on this committee for your tremendous support that this project and others in the medical and health and educational areas receive.

We have a fair audience we know when we come before you.

Mr. NATCHER. Thank you very much.

WEDNESDAY, MAY 7, 1986.

AHEC PROGRAM

WITNESSES

DR. ROBERT E. TRANQUADA, CHANCELLOR/DEAN, UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL, WORCESTER, MASSACHUSETTS

RICHARD H. SWIGART, ASSOCIATE DEAN FOR ACADEMIC AFFAIRS, UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

Mr. NATCHER. Our next two witnesses who will testify are Dr. Richard H. Swigart and Dr. Robert E. Tranquada. Mr. Early, I am going to yield to you to present the next witnesses that will be before the committee.

Mr. EARLY. I want to thank you for giving me this opportunity to present to you and Mr. Hoyer, Mr. Robert Tranquada, Dean of the University of Massachusetts Medical School, which is one of the finest medical schools in the country, located in Worcester, Massachusetts.

Mr. Chairman, I would like to say that these two gentlemen are here to testify on behalf of AHEC's.

Robert is here to testify on AHECs, a cost-effective way of providing good health care to the communities, whether it is in response to child abuse, Alzheimer's disease or AIDS. We appreciate you taking time out of your schedules because my colleagues know how busy both of you are.

Finally, Mr. Chairman, the AHEC at Dr. Tranquada's institution is in its eighth year of a nine-year funding cycle, so he is not down here on a parochial matter. He is here to say the AHEC program has been very productive.

I also wanted to put in the record that the AHEC program would have been eliminated in the last six years if it wasn't for you. This is not a politically sexy item, but a very practical, productive item, and you kept it in.

I wanted to be able to say that to you, because this is what good government is all about. I appreciate you taking the time to come down here.

Mr. **Natcher**. Gentlemen, we will be pleased to hear from you.

Dr. **Tranquada**. Thank you, Mr. Chairman.

Through you, may I thank Congressman Early for his gracious words and for providing the bulk of my testimony. I am Robert Tranquada, Chancellor and Dean of the University of Massachusetts Medical School, and I am here along with Dean Swigart to testify on behalf of the National Area Health Education Center Program, funded until Title VII of the Public Health Service Act.

Since 1972, the program has had activities in 32 States. See the list in my prepared statement. The essence of the program is to link medical schools and other health science schools to rural and inner city communities in order to bring health profession training programs to communities where they are needed.

The goal is to export the advantages of proximity to the University Health Science Center and thus attract physicians, nurses, dentists, pharmacists, and the entire array of allied health practitioners to choose to practice in areas of need.

AHEC might be best characterized as a bridge between the community, with its practicing health professionals, and their needs, and the health professions schools which possess important resources that can improve health care and recruitment of health professionals to more distant communities.

These efforts, coupled with our success in exposing students and residents to community practice and experiences will, we believe, make for a better health professions educational process; one that will best serve the country.

As of this past October, 32 AHEC projects had been funded nationally since the 10 original projects began in 1972. These 32 projects involve nearly 40 percent of the Nation's medical schools. Today, these projects account for 91 regional centers, in both rural and inner city areas, called AHECs.

It should be emphasized that this program is not one which adds to the supply of health professionals. Rather, it is one which increases the likelihood that professionals will practice where they are needed. The continuing presence of the program also increases the likelihood that practitioners will remain in the community and stay up to date with new medical knowledge.

The Massachusetts Statewide AHEC Program is midway through the eighth year of a nine-year anticipated AHEC funding plan. Our program includes Boston University Schools of Medicine, Nursing, Dentistry and Allied Health, as well as my own institution in Worcester.

Six Area Health Education Centers cover the Commonwealth of Massachusetts from Cape Cod to the Berkshires.

Our work during the past several years has included the securing of local and State funds to maintain the AHEC program in Massachusetts beyond the Federal funding cycle.

Similar successful efforts are evident in North Carolina, Ohio, South Carolina and California. Such efforts underscore an important point which I want to make: AHEC, as an outreach program of the University of Massachusetts and Boston University, has become an important vehicle with which both academic institutions relate to local urban communities and rural areas distant from our campuses.

We have found that the agenda of community needs, which now includes such important topics as preparing health professionals to deal with child sexual abuse, Alzheimer's disease and AIDS, continues to require the collaborative efforts of our academic resources working through the six regional AHECs in Massachusetts.

In other words, AHEC has proven to be a successful experiment in Massachusetts, which has proven itself during its Federally-funded phase, and which now will be continued through a local/State partnership in funding.

As you know, it is not an easy effort to shift the support of a complex program like AHEC from one dominant source of funding to another. Fortunately, we have a good, effective product and planning for alternate support began some time ago with our communities and the State legislature.

State agencies now regularly approach AHEC for assistance in meeting goals that fit into AHEC objectives.

I want to conclude my remarks by thanking you for your consistent support over the past eight years. This has been an important program for Massachusetts and we are indebted to the Federal Government for its creation of the AHEC program. We believe we have provided the best tribute to the Federal initiation by continuing the program with local and State support.

We have been proud to be a part of the National AHEC program, and we urge that the Congress continue to support of the AHEC program as these methods hold great promise for each of the States.

The National AHEC Program is an investment in access to health care for rural and inner city populations that our Nation cannot afford to do without.

I am pleased to present one of the most recently funded programs, the Kentucky AHEC Program, to provide a perspective from a newly initiated AHEC. Dr. Richard Swigart is the Associate Dean for Academic Affairs at the University of Louisville School of Medicine.

Mr. NATCHER. Thank you very much, Dr. Tranquada.

[The information follows:]

B. Projects in the National AHEC Program

LOCATION OF AHEC PROJECTS

FIRST GENERATION (PL 92-157)

(initial federal funding in 1972)

California (Central San Joaquin Valley):
    University of California, San Francisco
    University of California, Los Angeles
Illinois: University of Illinois
Maine: Tufts University
Minnesota: University of Minnesota
Missouri: University of Missouri-Kansas City
New Mexico: University of New Mexico
North Carolina: University of North Carolina at Chapel Hill
North Dakota: University of North Dakota
South Carolina: Medical University of South Carolina
Texas: University of Texas Medical Branch
West Virginia: West Virginia University

SECOND GENERATION (PL 94-484)

(initial federal funding in 1977)

Colorado: University of Colorado
Maryland: University of Maryland
Pittsburgh, Pennsylvania: University of Pittsburgh
Washington, D. C.: Howard University

(initial federal funding in 1978)

Connecticut: University of Connecticut
Massachusetts (statewide): University of Massachusetts
New Jersey: University of Medicine and Dentistry of New Jersey
Ohio (statewide):
    Medical College of Ohio
    Case Western Reserve University
    Northeastern Ohio Universities College of Medicine
    Wright State University
    Ohio State University
    Ohio University
    University of Cincinnati
South Dakota: University of South Dakota

SECOND GENERATION (CONT.)

(initial federal funding in 1979)

California (statewide):
- University of California, Davis
- University of California, San Francisco
- University of California, Irvine
- University of California, Los Angeles
- University of Southern California
- Stanford University
- Loma Linda University

Kansas: University of Kansas
Eastern Virginia: Eastern Virginia Medical School

(new starts: initial federal funding in 1984)

Arizona: University of Arizona
Georgia: Morehouse School of Medicine
Michigan: Michigan State University, Saginaw
Oklahoma: Oklahoma College of Osteopathic Medicine and Surgery
Tennessee: Meharry Medical College
Texas: Texas Tech University

(new starts: initial federal funding in 1985)

Maine: University of New England - College of Osteopathic Medicine
California: University of the Pacific, College of Osteopathic Medicine
Florida: Southeastern College of Osteopathic Medicine
New Mexico: University of New Mexico School of Medicine
W.A.M.I.: University of Washington
Kentucky: University of Louisville School of Medicine

Mr. NATCHER. Dr. Swigart, we will be pleased to hear from you.

Mr. SWIGART. I am Dr. Richard H. Swigart, Associate Dean for Academic Affairs at the University of Louisville School of Medicine, and Director of the Kentucky Rural Area Health Education Center Program.

I am here to add the perspective of the newer AHEC projects to the very complete and, I believe, convincing presentation of Dr. Tranquada.

The AHEC program in Kentucky is one of 12 Federally-funded AHEC programs in the planning and early development stage. These programs have made good progress but need funding support through the customary six-year term is they are to be as successful as the earlier AHEC projects; for example, Massachusetts, represented by Dr. Tranquada; North Carolina, Ohio, Illinois and California.

The progress in Kentucky has been dramatic. The Kentucky AHEC Program includes the medical and dental schools at both the University of Louisville and the University of Kentucky.

Professional programs in nursing, allied health and pharmacy are also included. Current plans call for the establishment of AHECs at Hazard, Morehead, Madisonville and Bowling Green.

The planning is well ahead of schedule, and health care facilities and leaders in the rural communities have responded with an unanticipated level of enthusiasm and support.

In northeastern Kentucky, every local hospital has joined in the AHEC effort. Much-needed library resources will be added in three Kentucky AHECs before the end of this year.

The Federal AHEC program, when joined with support by the State of Kentucky, allows the two academic health centers and the local communities to form a true partnership of government, private interests, the universities and small rural communities. Federal support is essential for the next few years if we are to continue the legacy of success.

Kentucky is a predominantly rural State with many people dependent upon small farms, mining and tobacco for their livelihood. All of these industries are currently in difficulty, resulting in a very high unemployment rate.

Many of the problems confronting rural Kentuckians are difficult to solve, but the AHEC problem can offer a better health care delivery system and a better distribution of health care professionals for a modest Federal investment through decentralized health manpower training and retention programs.

In addition to the Kentucky AHEC program, 11 other new AHEC programs are directing their efforts towards areas of particular concern within their States. I would like to refer to each of these new programs to emphasize the diverse nature of the AHEC program.

The Arizona and Texas AHEC programs are attempting to improve health manpower retention and distribution among the Hispanic population.

The Morehouse School of Medicine program is developing an urban AHEC along with rural centers in areas with predominantly minority populations.

The Oklahoma and Maine AHEC programs serve the Native American population and concentrate special efforts on attracting Indian students to, and preparing them for, the health professions.

The Southeast Florida program serves the indigent populations of the rural Everglades as well as inner city north Dade area of Greater Miami. The population includes migrant workers and Hispanics.

The Pacific Coast AHEC addresses the needs of the multi-cultural urban population of inner city Los Angeles.

The New Mexico AHEC is attempting to improve health services in the underserved areas of northeast New Mexico with a special emphasis on the needs of the mentally ill.

The Michigan program concentrates its efforts on the special needs of the people in the thinly-populated northern portion of that State.

The Tennessee AHEC being developed by the Meharry Medical College is addressing problems in rural Tennessee.

The Washington, Alaska, Montana, Idaho Area Health Education Network is building upon the four-State medical education network. This is an attempt to more effectively and efficiently serve the needs of 7,000,000 people, less than 3 percent of the Nation, scattered over an area encompassing one-quarter of the Nation's land mass.

The national AHEC program in Massachusetts, North Carolina, Ohio and elsewhere has been proven a wise investment for the Federal Government. AHEC has been a very successful new program that invariably has provided the impetus for State and local governments to appropriate hundreds of millions of dollars for educational initiatives directed toward the primary health care services for underserved populations in States where AHEC programs exist.

May I repeat, the National AHEC Program demonstrates a very successful and rare partnership between government and private health care providers, between universities and local communities, between the sophisticated technology of a university health center and the primary health care provider of some of our poor and isolated citizens.

Mr. Chairman, we of the AHEC program appreciate the support we have received, particularly from this subcommittee and the Congress. As I am sure you can tell from my statement, the participants in the AHEC program believe very strongly that this Federal program must continue.

Last year, Congress appropriated $18,000,000 for the AHEC program, and we would hope Congress can continue that level of funding for fiscal year 1987.

Thank you very much for this opportunity.

Mr. NATCHER. Thank you very much, Dr. Swigart. You have given us an excellent statement. We appreciate both of you appearing before our committee. Thank you again.

WEDNESDAY, MAY 7, 1986.

NIDDKD

WITNESS

DR. GERALD M. REAVEN, CHAIRMAN, NATIONAL DIABETES ADVISORY BOARD

Mr. NATCHER. Our next witness is Dr. Gerald M. Reaven.

Dr. REAVEN. I am Gerald M. Reaven, Head, Division of Gerontology, Stanford University School of Medicine, and Chairman of the National Diabetes Advisory Board. The Board was established by Congress to review and evaluate the implementation of the long-range diabetes plan and to report annually to Congress and the Secretary of HHS on recommendations for future policies, programs and budgetary requirements.

A copy of the Board's most recent annual report will be provided to the subcommittee today. It would not be useful to summarize that report, but try to make a few general comments.

Diabetes has been a disease characterized by great triumphs and equal feelings of despair. In 1925, with insulin availability, there was a sense that we had conquered this disease, that people would live happily ever after.

It took 15, 20 years to realize this wasn't the case, and suddenly we saw blindness developing, kidney, heart disease developing. As of now, blindness is the major—excuse me, disease is the major cause of blindness in adult Americans.

Approximately one-fourth of all end stage kidney disease is due to diabetes, and it is the major cause of heart disease. By the end of 1960, the period of greatest despair, many authorities felt there was no possible way to treat this disease. In the long run, we had to live with the notion that patients with this disease would have these problems.

The situation has changed dramatically in the past 10 to 15 years. For example, we know now there are at least two major types of diabetes, and one is called Type 1 diabetes, and Aaron Rich, you saw today, has Type 1 diabetes.

These are individuals with a normal immune response, they destroy their own pancreas and they require insulin for survival.

In the last two years, we have learned who gets that disease and for the first time, we are thinking about actual prevention of Type 1 disease. That is a few years off, but already there are successful efforts at pancreatic transplantation, a way to begin to give back to patients who have no functional pancreas, pancreatic cells.

We now have better modes of therapy, an area Ron talked about, his ability to measure the blood glucose concentration, and there is an enormous ability to treat this disease, all due to research.

Type 2 diabetes, the other major syndrome, these patients have insulin in their blood, but it doesn't work correctly, and we now know why it doesn't act correctly. There has been enormous increase in knowledge how insulin receptors are regulated, and we have cloned genes for the glucose transport units, and these are enormous accomplishments in the past five years, and there has been progress in translation.

CDC has initiated programs with the States, and the research progress to make sure therapy is parallel to research progress. Unfortunately, at a time of enormous hope, we have had a situation of declining funds, which is getting worse and worse.

For example, right now about one-fourth, only one-fourth of all approved research grants and diabetes-related research will be funded this year. Of those one-fourth, all will be cut back 10 to 15 percent.

This is a disaster, and a change at a time when momentum is growing. Maybe of greater importance is the fact that there are marked reductions in training funds for new investigators, and these young people see no training funds, and research grants being cut, and we are losing a whole generation of researchers, and this is a disaster.

I could go on and on. Time doesn't permit this. This is a time of great progress and there are marked cutbacks. Resources are not infinite, but at some point, one begins to cut funding to a point where it is false economy.

We are losing what we are gaining, and we are now at that point in diabetes. We have made six suggestions to add money back to the proposed budget. One we think that the NIADDK, which is the major diabetes research center, should be funded at a level of $503,000,000.

A second major program about to be cut is the CDC's National Diabetes Control Program. We strongly recommend that that 7,400,000 be put back in that program, and there are many other specifics in the report, which I know you will read, and we appreciate your support in the past and in the future.

Thank you very much for your attention.

Mr. NATCHER. Thank you very much for your appearance before the committee.

[The statement of Dr. Reaven follows:]

STATEMENT OF GERALD M. REAVEN, M.D.

Member, National Diabetes Advisory Board

Before the House Subcommittee on Labor, Health and Human Services,
and Education and Related Agencies on Appropriations

(Appropriations for Diabetes-Related Research - NIH)

Wednesday, May 7, 1986

I am Dr. Gerald M. Reaven, Head, Division of Gerontology, Stanford University School of Medicine, and Chairman of the National Diabetes Advisory Board. The Board was established by Congress to review and evaluate the implementation of the long-range diabetes plan and to report annually to Congress and the Secretary of HHS on recommendations for future policies, programs, and budgetary requirements. A copy of the Board's most recent annual report will be provided to the subcommittee today. The report describes the tremendous progress of the diabetes program during the last decade and the significant opportunities for future advances both in research and its application to treatment.

Diabetes is a serious disease of major proportions in the United States. For example, it is the leading cause of adult blindness. Diabetes also accounts for about 25 percent of all cases of kidney failure and 45 percent of all non-traumatic amputations in this country. In addition, people with diabetes are twice as likely as the general population to die of heart disease, and 2 to 6 times more likely to suffer a stroke. The perinatal death rate of infants of diabetic mothers is 2 to 4 times higher than in nondiabetic pregnancies.

Diabetes is also a costly disease. Costs directly attributable to diabetes are conservatively estimated at $13.8 billion annually. Included in this figure are $7.4 billion for direct medical care expenses and $6.4 billion for indirect costs due to disability and premature death. A major portion of this economic burden falls directly on the Federal government and the taxpayer through the Medicare and Medicaid programs and the direct health care responsibilities of the Veterans Administration, the Indian Health Service, the Department of Defense, and other Federal agencies. For example:

- The total costs to Medicare for End-Stage Renal Disease associated with diabetes are approximately $330 million per year.
- Approximately 40,000 people with diabetes are blind and 5,800 new cases of diabetes-related blindness occur each year. The cost to this country in associated public welfare expenses and lost income is approximately $75 million annually.
- Hospitalization costs for diabetes-related lower extremity amputations were about $300 million in 1980, which does not include rehabilitation, premature death, or disability costs. A major share of these expenses are borne by Federal health care programs.

Major advances in biomedical research supported by the National Institutes of Health have greatly expanded our understanding of the pathogenesis of diabetes. Perhaps the most exciting advances in the past year or two are in understanding the role of immune mechanisms in insulin dependent diabetes, which affects mostly children, in developing strategies for pancreas/islet cell transplantation, in clarifying the structure of the genes for insulin and the insulin receptor, and in clarifying the mechanisms of insulin action.

For example, during the past year, there has been very significant progress in research related to transplantation of islet cells. These advances have reached the point that three centers in this country have initiated clinical trials involving islet transplants in patients with advanced diabetes who already are receiving immunosuppression for maintenance of kidney grafts. These initial studies have clearly demonstrated partial function of transplanted islets in the majority of recipients. Additional centers are conducting studies to define the effects of immunosuppression on islet engraftment and function and to improve the quality and quantity of islet tissue for transplantation.

Research related to noninsulin dependent diabetes, which affects mostly adults, also is progressing. For example, techniques of modern molecular biology are allowing detailed elucidation of the structure of key genes, in particular the insulin gene and the insulin receptor gene. This research will increase our understanding of how insulin controls carbohydrate, lipid, and protein metabolism and what causes the insulin resistance characteristic of noninsulin dependent diabetes.

These and many other advances offer significant hope that the tragic human costs and major economic burden associated with this disease can be significantly reduced in the coming years if existing diabetes research programs are maintained and strengthened. Diabetes research is clearly cost effective. The accomplishments of the past decade have already provided improved treatment strategies whereby blindness, amputations, and perinatal mortality can be reduced, saving hundreds of millions of dollars annually. However, future advances will not occur without adequate support for diabetes research programs.

Most of the recent advances in the prevention, treatment, and control of diabetes are a result of increased Federal support for biomedical research during the mid and later 1970s. This impetus has not been maintained in the 1980s, since funds for these programs have not kept pace either with inflation or with the increased opportunities for research advances. For example, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the lead institute for diabetes research, has historically funded approximately 45 percent of approved, scientifically meritorious research applications. The award rate will decline to about 25 percent in 1986 and would have been lower if the budgets of previously awarded grants had not been administratively reduced below recommended levels.

The Board recognizes that Federal resources are not infinite. However, the continuation of recent funding trends, in our opinion, will lead to the following results:

- We will lose a major opportunity to reduce the burden of diabetes if we do not take advantage of promising research opportunities that could lead to the prevention and cure of diabetes, including research related to the role of the immune system in the initiation of diabetes and the use of pancreatic islet transplantation to correct the basic diabetic condition.

- We will lose an entire generation of future basic and clinical research investigators, as bright young trainees become discouraged by both the limited number of fellowships and career development awards and the reduced likelihood of receiving research support following their training.

- Research projects already approved and funded will be severely hampered because of the large budget reductions that are being imposed upon all NIH research projects.

- The leadership of the national diabetes program will be severely hampered by reductions in the number of Federal personnel. For example, the staff of the National Institute of Diabetes and Digestive and Kidney Disease has been reduced by 70 positions in the past 18 months, and additional reductions are anticipated.

Diabetes research programs should be strengthened, not reduced. The accomplishments of the past decade provide evidence that the Nation will benefit from a strong national diabetes effort. Therefore, the Board has provided budget recommendations for the major Federal agencies participating in this program (table 1).

Table 1

BUDGET RECOMMENDATIONS FOR DIABETES-RELATED RESEARCH PROGRAMS*
(Millions of Dollars)

National Institutes of Health	1986†	1987
NIDDK	109.5	121.0
NHLBI	20.5	22.0
NEI	23.2	26.0
NICHD	11.9	13.0
NINCDS	4.7	5.5
NIAID	5.9	7.0
NIA	2.2	2.2
NIDR	4.9	5.0
NIGMS	1.1	1.2
NIEHS	.3	.5
DRR	15.5	17.0

*Amounts are only for diabetes-related activities only. However, the Board recommends a total budget of $503 million in FY 1987 for the National Institute of Diabetes and Digestive and Kidney Diseases.

†Original 1986 congressional appropriation.

The Board recommends a funding level of $503 million for the National Institute of Diabetes and Digestive and Kidney Diseases. NIDDK is responsible for planning and implementing a comprehensive national diabetes research program. It also is the major source of support for training in diabetes-related research disciplines. Special programs of the Institute include the Diabetes Endocrinology Research Centers, the Diabetes Research and Training Centers, the Diabetes Control and Complications Trial, the National Diabetes Information Clearinghouse, and the National Diabetes Data Group, all described in our annual report. The Board's budget will enable the Institute to fund approximately 33 percent of approved individual research grants at the levels recommended by the scientific review committees, support diabetes centers at recommended levels, restore manpower development awards to the 1985 level, fully fund phase III of the Diabetes Control and Complications Trial, and enable the Institute to recruit key staff members.

Many other NIH Institutes and Divisions support diabetes-related research. The Board's budget recommendations (table 1) contain funds for these programs. Included are those of the National Heart, Lung, and Blood Institute (cardiovascular consequences of diabetes), National Eye Institute (ocular complications of diabetes), National Institute of Child Health and Human Development (effects of diabetes on pregnancy and infants), National Institute of Allergy and Infectious Diseases (infections and immunogenetic factors in diabetes), National Institute of Neurological and Communicative Disorders and Stroke (neurological complications of diabetes), National Institute on Aging (interrelationships between diabetes and aging), National Institute of Dental Research (dental complications of diabetes), National Institute of Environmental Health Sciences (relationship between environmental agents and pancreatic structure and function), and National Institute of General Medical Sciences (the training of physician-scientists). In addition, the General Clinical Research Center program of the Division of Research Resources supports non-categorical clinical research facilities in which the vast majority of all clinical investigations related to diabetes are conducted. All of these programs should receive additional funds for their diabetes-related research activities.

The Board also recommends funds to continue the national Diabetes Control Program of the Centers for Disease Control (CDC). This agency has developed a national strategy to apply current research advances to the prevention of some of the complications of diabetes. Working with state agencies, the CDC has developed cost effective programs that already have reduced diabetes-related hospitalization costs in selected project areas. The Board strongly recommends that the CDC program receive $7.4 million in fiscal year 1987, the same level Congress provided in fiscal years 1985 and 1986.

WEDNESDAY, MAY 7, 1986.

INTERSTITIAL CYSTITIS

WITNESS

DR. VICKI RATNER, MONTEFIORE/EINSTEIN MEDICAL CENTER, INTERSTITIAL CYSTITIS ASSOCIATION

Mr. NATCHER. Our next witness is Dr. Vicki Ratner, and we will be pleased to hear from you at this time.

Dr. RATNER. I would like to thank you very much for giving me the opportunity to represent the ICA. I am representing the Interstitial Cystitis Association.

Interstitial cystitis, IC, is a disease that very few people have heard of. I certainly never heard of it, even as a physician, until I unfortunately came down with the disorder myself.

IC is an inflammation of the bladder wall. No one knows the cause, and there is no cure. Chronic inflammation causes scarring which causes the bladder wall to stiffen. This results in a decreased bladder capacity leading to a constant, urgent need to urinate.

It is a very painful condition, and although it is not a terminal illness, has led to suicide attempts and suicides. Symptoms are similar to a urinary tract infection, except that it is not caused by a bacteria, and therefore does not respond to antibiotics. It has been described like "a knife in one's bladder, or a lit match in one's pelvis."

Patients are forced to live with chronic, severe, debilitating pain. There are many suicidal attempts.

Most women are unable to have intercourse, and therefore unable to have children. This leads to many divorces, and in younger women, essentially halts any normal social life, or prospects of marriage.

Many patients have to urinate as many as 60 to 100 times a day. These patients are literally confined to their homes, cannot travel, or function normally in any way. They can't even make it to the local supermarket.

Because of these problems, patients are unable to keep their jobs.

In addition to the devastating pain of this disease, the typical victim often goes undiagnosed or is misdiagnosed for many years. Many patients with IC have seen more than 10 doctors before the diagnosis is made.

Very little is known about this disease. Once considered rare, it is now estimated that over 500,000 people in the U.S. are afflicted with this disease. The ratio of female-to-male is 10 to 1. There have been no formal studies on incidence ever conducted in this country.

Some treatments are available that afford temporary relief to some patients, but most have nowhere to turn for help. In the past, IC was considered a psychosomatic disorder, one of these female "hysterical" ailments.

This myth was perpetuated in Campbells' Urology, the standard urology text, until recently, August 1985, when the chapter was finally rewritten, and IC was given its proper place as a real disease.

We now face the problem that many urologists have been trained on inaccurate and outdated information. This adds to the problem of early diagnosis.

As an organization, the ICA had done remarkably well in the two short years since we established ourselves. With the help of the media, including the New York Times, Washington Post and Good Morning America, ABC nationwide TV, we have all found each other and established a network all across the United States.

We have a superb Medical Advisory Board, with the best urologists in the country. We have top medical centers interested in doing research: University of Pennsylvania, Boston University, Tufts Medical Center, University of California at San Diego, et cetera.

So little has been done on IC, we feel that in a relatively short period of time, with funding from NIH, that we can find an answer.

The first national medical conference on this disease will be held in Boston this September. Without funds, research cannot continue, and thousands of us will be forced to exist under agonizing conditions day in and day out without any hope.

I would like to read a paragraph written to us by a young woman from California:

"In the past six months, my condition has intensified to the point where I am unable to function as a normal human being. Crippled with pain, I have been unable to pass the California Bar Exam, unable to work, and have had to cease all sexual activity with my husband. In the past few weeks, I have been bedridden with pain."

I have had IC for three years and live with chronic pain. Unlike many other organizations, our members are all victims of IC and are sick and unable to fight for research and treatment. There are many people more debilitated than I from States throughout the country.

With great effort, I made this trip to Washington and am speaking on behalf of all those home-bound, too sick to come and ask for your help. There is not one drug that can be used effectively to lessen the pain. We have thousands of women today, and men, diagnosed with IC who have nowhere to turn to for help.

There is no cure for IC. There are a few treatments that offer temporary relief to a small portion of patients. Elmiron, which is not approved by the FDA, has been made available through the cooperation of the NIH to urologists who make a special request application to the NIH.

We are most appreciative of the efforts of the NIH to make this drug available, as initially it was very promising. Unfortunately, it has not been very successful, leaving thousands of patients with nowhere to turn to for help.

More research needs to be conducted for better, safer treatments using larger patient population studies.

We appeal to you today to help find a cure, and initiate research that would provide a drug for safe and long-term relief.

Without funds, we have no hope. Please help us. Thank you.

[The statement of Dr. Ratner follows:]

ICA Interstitial Cystitis Association
P.O. Box 1553, Madison Square Station
New York, N.Y. 10159

In the past two years the following media have covered our efforts.

I. Books
   "Interstitial Cystitis", chapter in Cooperative Approaches to Research and Development of Orphan Drugs, Liss, 1985.

II. Medical Press
   - Neurourology and Urodynamics (Fall '85)
   - Hospital Satellite TV Network (May '85)
   - Physicians' Radio Network (May '85)
   - Medical Tribune (February '85)
   - American Journal of Nursing (January '86)

III. Newspapers
   - Washington Post (September '85)
   - New York Times (December '84)
   - Philadelphia Inquirer (August '85)
   - New York Daily News (April '85)
   - City On A Hill, Santa Cruz, California (October '84)
     (state journalism award for outstanding science reporting)
   - Syracuse Post-Standard (May '84)
   - Syracuse Herald (May '84)

IV. Television
   - NBC Today Show (April '86)
   - ABC Good Morning America (April '85)
   - Cable News Network (October '84)
   - WABC-TV Eyewitness News (May '85)
   - WNBC-TV News 4 New York (May '84 and Oct '84)
   - WCBS-TV Evening News (Dec '84)
   - AM Philadelphia TV (January '85)
   - WSTM-TV Syracuse News (May '84)

V. Radio
   - NBC Radio Network (May '85)
   - ABC Radio Network (May '85)

VI. Magazines
   - Ms. (September '85)
   - Working Woman Magazine (January '86)
   - Glamour (November '85)
   - Women's Health Network (Spring '85)
   - Women's World (September '85)
   - Savvy (June '86)

ICA update

VOLUME 1 NUMBER 3 WINTER 1986

P.O. Box 4178
Great Neck, NY 11027

THE INTERSTITIAL CYSTITIS ASSOCIATION

A Note From the Board: Vicki Ratner
Cheryl London
Barbara Seiden
Mona Schlossberg

Dear friends of ICA,

As we begin a new year of work we wish to thank all of you for your support and generous contributions.

Since our fall newsletter we have accomplished many things.

1. We are now a not-for-profit organization. This is a tremendous boost to our fundraising drive since all contributions are now tax deductible.

2. Our first general meeting was held on November 17th at the New York University Medical Center. The day was a tremendous success. We had over 100 attendees and the states of Arkansas, Florida, Maryland, Massachusetts, Michegan, New York, New Jersey and Pennsylvania were represented. Plaques were given for outstanding contributions to the ICA. Drs. Phil Hanno, Bob Levin and Michael Ruggieri from the University of Pennsylvania gave a presentation based on their research supported by the ICA, and sufferers had the opportunity to meet and speak with other sufferers.

A Complete Transcript of the Meeting is now available. If interested send **$15.00** to: ICA
P.O. Box 1553
Madison Sq. Station
New York, NY 10159

3. Our first National I.C. Medical Conference is planned for September 1986 in Boston. This is a major breakthrough for us since urologists from all over the U.S. and Europe will be attending.
4. *We are pleased to welcome Dr. Sant of Tufts University medical Center to our Medical Advisory Board.
5. Mona Schlossberg appeared before the board of the Food and Drug Administration, U.S. Department of Health and Human Services, orphan drug meeting on December 11th. She presented a plea on our behalf for research funding and better treatments. Two drug companies, Revlon Research Division and Medical Market Specialties both showed interest in our cause and these contacts are being followed up.
6. The University of Pennsylvania research team continues to work diligently for I.C. research. Unfortunately, their recent grant proposal to NIH was rejected. This is a major setback for us and we need to concentrate our efforts on fundraising and political action.

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*It is **imperative** that each of us **write** to our **congressmen** to demand that funding be made available for I.C. research. Call or write us or your state coordinators for a sample letter.

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7. Dr. Vicki Ratner has requested an appointment to testify before the Senate and House of Representatives subcommittee hearings for funding from NIH.
8. Our National Telephone Support Network is now underway in 15 states.
9. ICA was included in a recent medical question and answer article on women's health problems in *Women's World* magazine, December 17th issue, and in an article in the January issue of *Working Woman* magazine.

Announcements:

1. Elmiron, though not approved by the FDA, is available through special application. A request for Elmiron can be made by having your urologist write to Mr. Jim Hannan, Division of Surgical-Dental and Orphan drug department of the FDA: HSF-160
   5600 Fisher's Lane
   Rockville, MD 20857

2. Women who have been pregnant with I.C. should send their name, address and telephone number to:

Dr. G. Farahani
1077 Northern Blvd.
Roslyn, NY

Dr. Farahani will be contacting you for a case history study on the effects of pregnancy on I.C.

Speaking of Pregnancy:

Barbara Seiden had a baby boy, Adam Marshall, delivered by Dr. Farahani on September 30. Mother and baby are doing fine.

A Note of Thanks:

We wish to thank:

Mona Schlossberg for her outstanding effort on our behalf in Washington DC.

Judith Heller for her relentless drive and hard work as ICA's controller.

Our State Coordinators for all they've done to make our national network possible.

David Barg for his planning and reorganization of our general meeting.

Dr. Farahani for his interest in I.C. and his forthcoming case history.

A Final Word

Although we have made a great deal of progress we have a long way to go. We need your continued support and contributions. Let your New Year's resolution this year be your renewed commitment to the I.C.A. Send your tax deductible contribution to:

I.C.A.
P.O. Box 4178
Great Neck, NY 11027

Upcoming Events:

We look forward to meeting you at our Spring fundraising event. Details will follow as soon as they are finalized.

With best wishes for the New Year,
ICA Directors
Vicki Ratner
Cheryl London
Barbara Seiden
Mona Schlossberg

Neurourology and Urodynamics 4:153–155 (1985)

EDITORIAL

"Tell Her to Get a Urine Culture, Take Some of That Medicine I Prescribed a While Ago, and Call Me in a Few Days"

One has only to look at recent issues of our journal and others which publish on related subjects to acknowledge that many of us (me included) spend a great deal of time studying interesting but distinctively uncommon problems or ones which are in large measure of theoretical rather than practical concern. In spite of this, there exists a very large group of patients with mundane-sounding, but sometimes disabling, symptoms for which we have no explanation or rational treatment. Probably the largest group of these consists of females with complaints which we group under the heading of the urethral syndrome—ie, any combination of unexplained frequency, urgency, dysuria, incontinence, suprapubic or perineal pressure/pain/discomfort, hesitancy, weak stream, feeling of incomplete emptying, malaise, and dyspareunia. Lower urinary tract symptomatology can be expressed in only so many ways, and the list of disorders with potentially similar symptomatology of this type is very long and includes neoplastic, infectious, anatomic neurologic, urodynamic and emotional etiologies. Unfortunately, after neoplasia and obvious infection have been excluded, these problems tend to occupy a low priority on most global concern lists with one notable exception, that of the patient so affected. The following statement was submitted to our journal as an editorial by one of these patients who happens to share our vocabulary:

> When I was told that I would have to live with severe pain for the rest of my life, I was devastated. But when I was told that I had brought the disease upon myself, that it was all in my head, that the solution was to quit medical school and settle down to a traditional life style, I marched off to the library. My research revealed a disease I had never heard of . . . interstitial cystitis.
>
> I am writing this in the hope that it may give physicians a better understanding of the disease so that patients in the future will not have to go through the long, tortuous process I did in being diagnosed. After a total of ten urologists and eleven months later, I finally made the diagnosis myself.
>
> I am thirty-four years old, otherwise healthy, with a history of recurrent urinary tract infections. Two years ago, I experienced the sudden onset of severe suprapubic pressure, burning, frequency and urgency and assumed it to be yet another urinary tract infection. But this time urine cultures were

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negative, and symptoms persisted despite a course of antibiotics. Further workup including a cystometrogram, intravenous pyelogram, special cultures for mycobacterium tuberculosis and chlamydia, and a complete gynecological exam were all negative. Cystoscopy in the office revealed normal bladder mucosa with a normal bladder capacity. And I was left to live with debilitating symptoms, told that the problem was due to stress and that I should seek psychiatric care.

The first weekend in the library on my research endeavor, I came across an article by Dr. Thomas Stamey, that described 50 cases exactly like mine—persistent symptoms of a urinary tract infection, but with a negative workup. I read further that in order to make the diagnosis, the doctor must place the patient under general anesthesia, and overdistend the bladder hydraulically; it is the presence of small petechial hemorrhages that confirms the diagnosis. I brought the article to my urologist, but it took months of convincing before he would place me under general anesthesia. Finally the diagnosis was made.

The problem I faced was that I had come down with a disease about which very little was known, on which little research was being done, the diagnosis and treatment of which was surrounded by controversy. I spent the last two years of medical school in intense, unremitting pain, and in isolation, imagining that I was the only one in the world with this disease.

Fortunately, I was able to contact several other patients who had interstitial cystitis with the help of Dr. Stamey. I was as astounded as I was relieved to find that my case was not unique. Since then we have started a national organization and have begun work on a National Registry. Working together with these patients and researchers at my medical center on finding a cure for this disease has been a source of tremendous comfort and support. Media attention has brought thousands of us together from across the United States.

I have found that most physicians, in particular, urologists, have very little understanding of this disease, and as a result attribute it to psychological causes or do not take it seriously. Although the disease is not life-threatening, its impact on one's life can hardly be overstated, indeed can barely be imagined by anyone who has not suffered from it. Moreover, it is almost impossible to travel or even go out for an evening, to a movie or restaurant. The disease can necessitate as many as 50–60 trips to the bathroom per day. It is almost impossible to carry on the sustained effort and concentration required by professional training or by a career.

Although therapy for interstitial cystitis is at present investigative, there is tremendous relief to be gained from a diagnosis and the knowledge that the disease exists and is not psychological. Treatments are available that alleviate some of the symptoms. These include hydraulic distention of the bladder, DMSO, chlorpactin, and silver nitrate.

I hope that physicians will further inform themselves about interstitial cystitis so that they can make an early diagnosis and refer their patients to the national organization concerned with this disease. Perhaps interstitial cystitis is not as rare as the literature claims.

Interstitial Cystitis Association, Inc.
PO Box 4178
Great Neck, New York 11027

We may not agree with the implications of this statement, but we cannot ignore the fact that many such patients exist and that we have made few real, agreed-upon contributions to their evaluation or treatment in recent (or nonrecent) years. The fact that some of these patients have felt it necessary to form a group to assist each other certainly supports this notion. I personally have no idea what the true incidence of interstitial cystitis is in this patient population. I am not even sure what interstitial cystitis really is. However, I do know that, if we, the supposed "experts," do not adopt an attitude of genuine concern for these patients and focus the same expertise of our centers on this problem that we do on other more definable and readily explainable phenomena, we will be faced with a plethora of popular but what we consider scientifically unsupported "answers" and treatment regimens which these patients will actively seek out. All of us recognize that drawing conclusions about etiology or treatment from results obtained with nonrandomized "built-up" therapy without controls can be totally misleading. Why, then, not spend some time now carefuly looking into the problem so in the future we will have something more meaningful to say than that we think the use of bladder instillations of dimethylcorticodigomycinsulfopactin is without scientific merit.

Alan J. Wein, MD

WEDNESDAY, DECEMBER 5, 1984

THE NEW YORK TIMES

Personal Health

Jane E. Brody

Obscure bladder ailment that tries physicians as well as its victims.

AS if severe pain and embarrassing symptoms that do not respond to usual treatments are not bad enough, to be told that a devastating health problem is "all in your head" can make anyone frustrated and hostile. Trying to treat people with chronic debilitating symptoms that do not go away despite the best therapeutic efforts can be equally discouraging for doctors — enough so that they often turn their backs on such patients.

This is what often happens to the victims, most of them women, of a bladder disease called interstitial cystitis, a disorder that is difficult to diagnose and, at present, difficult to treat and impossible to cure.

Though a rare and not life-threatening ailment, its symptoms — severe pain and frequent need to urinate, sometimes as often as 60 or 70 times a day — make life an unrelenting agony for some of its victims. They may be unable to work or leave their homes; sexual intercourse and pregnancy may be impossible; some say they have attempted suicide.

Interstitial cystitis destroys the lining and elasticity of the bladder wall. Instead of being able to expand and contract readily, it becomes scarred and stiff. Where a normal bladder can expand to hold about 12 ounces of urine, a severely afflicted one may hold only two or three ounces. As urine fills the unyielding bladder, the pain and sense of urgency can become unbearable.

Interstitial cystitis afflicts 10 times more women than men and involves a field of medicine, urology, in which all but a handful of the practioners are men. Women say that the doctors do not grasp what it is like to live with symptoms that mimic infection but are not relieved by antibiotics.

Typically, women with the condition have been seen by urologist after urologist, many of whom suggested that stress was the cause and advised the women to seek psychiatric treatment. Although stress can aggravate the pain and anxiety associated with any disease, experts find no evidence that it causes interstitial cystitis.

The disease is admittedly rare. No survey of its incidence has been taken in this country, but in Finland, where detailed and extensive health records are available, it has been found to afflict [illegible] women and 8 men among every million people. Others say that 10 times this number are affected in the United States but have not been properly diagnosed.

Although itself uncommon, interstitial cystitis exemplifies a wide range of medical conditions that patients find it troublesome to live with and that doctors find it hard to diagnose and treat. Patients usually come back again and again complaining that nothing has really helped.

Eventually they move on to another doctor and repeat the unrewarding workups and unsuccessful therapies. Such disorders are also ripe for quackery, with desperate victims turning to vitamin megadoses and a host of herbs and unproven drugs.

Testing a promising new remedy is a challenge, since pain cannot be measured objectively and almost any new treatment — including those subsequently proved useless — will bring relief to many or most sufferers at first because they expect it to work.

According to a crusading victim of interstitial cystitis, Dr. Vicki Ratner, herself in medical training, physicians could best help patients by offering empathy rather than a cold shoulder or psychiatric referral.

"Patients need to know they are not alone and not crazy and that someone understands how miserable they are," said Dr. Ratner, a resident in orthopedics at Montefiore Medical Center in New York. The same could be said for any diseases, especially those of shrouded origin, difficult to diagnose and impossible to cure.

As with other chronic diseases, common and rare, a patient-support group has been established, the Interstitial Cystitis Association, with chapters thus far in New York and California. The organization provides information and camaraderie for patients and tries to stimulate medical research into causes and treatment.

Theories abound on the origins of interstitial cystitis. Dr. Eliahu Laor, a urologist at Einstein-Montefiore Medical Center, believes it is the end result of a diversity of conditions. Physicians have cited repeated injury to the bladder wall from recurrent urinary-tract infections, damage caused by the antibiotics used to treat such infections, allergic reactions, the use of such birth-control devices as the diaphragm (which may cause pressure on the bladder) and an autoimmune reaction in which the body mistakenly produces antibodies that attack the bladder lining.

The evidence to support any of these as causal agents is meager. However, researchers at the University of Denmark have recently isolated an abnormal protein from the blood and urine of victims that could be a clue to the cause and may facilitate diagnosis.

The disease generally manifests itself as if it were an ordinary urinary-tract infection, a problem all too familiar to about [illegible] percent of women and girls. In such an infection microorganisms can be found in the urine that are usually rapidly killed by the appropriate antibiotic. In interstitial cystitis, on the other hand, no bacterial or fungal culprit can be found and antibiotics do not help.

Proper diagnosis, then, must start with an examination of the urine for microorganisms. A special X-ray of the kidneys is taken to check for abnormalities, followed by a cystometrogram, or neurological evaluation of the bladder. The bladder must also be checked for the presence of cancer, which can produce the same symptoms as interstitial cystitis. Doctors must also insure that no other neurological disease is the underlying cause.

If all these tests are negative, the next and most essential step is a cystoscopic examination of the bladder under general anesthesia. With the patient unconscious, the urologist is able to distend the bladder enough to reveal the telltale signs of the disease: tiny red marks that represent pinpoint hemorrhages in the wall. These are present even in the early stages of interstitial cystitis, before the bladder's capacity has been noticeably reduced. A biopsy of the bladder may also be taken to check for swelling of the lining tissue and destruction of the muscle layer.

Although neither cure nor reversal is available, physicians can offer treatments — including medications that suppress the immune response or that reduce inflammation — that will bring some relief. The drug DMSO, which is marketed as Rhimso 50, has been approved for administration to patients, though, Dr. Laor says, the evidence for its effectiveness is very limited.

Other initially promising therapies — such as a substance called Elmeron, which coats the bladder wall, protecting it from acid burn by urine — do not seem to be holding up under critical study. Some patients are helped by psychotherapeutic tools that increase tolerance of pain.

Surgery to extend the bladder by attaching a piece of intestine has not worked because the new tissue is also affected by the disease. When all else fails, desperate patients may have to resort to surgical removal of the bladder; although a drastic solution (the urine must be diverted to a bag attached to the abdomen), it can be the preferred alternative.

Perhaps the most important lesson to learn from interstitial cystitis is how to deal with the medical profession when faced with a perplexing symptom. Dr. Laor says patients should never allow doctors to ignore or ridicule their questions. At the same time, if the doctor has approached diagnosis and treatment systematically and is empathetic, patients should not flit from one doctor to another, repeating painful and even dangerous tests and trying unproved remedies. Nor should patients resort to treatments meted out by nonphysicians or be offended if a physician suggests a psychiatric consultation.

Aid and Comfort

Patients and their families may write to the Interstitial Cystitis Association at P.O. Box 4178, Great Neck, N.Y. 11027, or P.O. Box 151323, San Diego, Calif. 92115, for educational material, contacts with fellow sufferers and possible physician referrals.

The Washington Post
A WEEKLY JOURNAL OF MEDICINE
HEALTH
FITNESS AND PSYCHOLOGY

The Human Body

'The PMS of the '80s'

Once a 'Closet Disease,' Interstitial Cystitis Now Recognized as a Common Problem

By Janis Johnson
Special to The Washington Post

When Vicki Ratner, a third-year medical student, was struck with severe bladder pain, she went to a urologist expecting another diagnosis of cystitis, a recurring urinary tract infection common in women. The pain, which wouldn't go away, "felt like I had a knife in my bladder," Ratner recalls, but the doctor could find nothing wrong.

One year and 14 doctors later, and after several hours of medical research of her own, Ratner finally received her diagnosis: interstitial cystitis (IC)—a disease for which there is no known cause, reliable remedy or cure.

But Ratner's crusading efforts in forming the Interstitial Cystitis Association has focused attention on a disease typically relegated, as she puts it, "to wastebasket diagnoses of women's complaints."

In fact, the disease occurs in both women and men, but is more common in women.

When Ratner, now an orthopedic surgery resident at the Bronx's Montefiore Medical Center, appeared on ABC's "Good Morning America" in April, she received 10,000 letters from distraught IC victims.

Many IC victims report they cannot have sexual intercourse because of the severe pain and are confined to their homes because of the urgency to urinate 50 to 60 times a day. Some have attempted suicide, says Ratner.

Marriages have broken up and some victims have had to quit their jobs. One woman in northern New York can't travel to New York City anymore because she is unable to get through the Lincoln Tunnel without needing to urinate.

"I hate to point a finger" at the predominantly male urology speciality, Ratner says, "but women's complaints [about the disease] haven't been taken seriously."

Ratner considers herself lucky because her training in medical research led to a relatively quick diagnosis.

Some doctors told her it was all in her head. "Several said it was stress and would go away," she said. "I got the typical find-a-boyfriend-and-get-married response. It was humiliating. When doctors don't know what something is, they say it's psychosomatic."

"IC is real, though," says Dr. Philip M. Hanno, director of the new Women's Center for Interstitial Cystitis at the Hospital of the University of Pennsylvania in Philadelphia. The hospital is one of about a dozen IC research sites across the country.

"Many doctors are not taking IC seriously," he adds. "It's the PMS of the '80s," referring to premenstrual syndrome, which only recently has been recognized as a series of hormonal changes affecting mood and physical well-being prior to menstruation.

"People who have IC are not crazy, although they may get crazy because of it," says Hanno, who personally sees three to four new IC patients a week. About 10 to 15 percent of the cases are extremely severe, he says.

IC is difficult to diagnose. The symptoms mimic common cystitis, which usually is eased by antibiotics within 24 hours or by home remedies, such as drinking cranberry juice.

But these treatments don't relieve IC. In addition to the frequent need to urinate, there is burning during urination. Usually victims suffer severe abdominal pain, either chronic or intermittent.

Once thought to be rare, IC is now believed to be common, although no studies have been done to determine its frequency. Researchers do know the symptoms show up 10 times more often in women than men, but they do not know why.

The disease is not new—it first was described in 1830s as an inflammation of both the bladder muscle and bladder lining and later as small ulcerations in the bladder. Yet these descriptions are insufficient compared with what doctors find today if they perform a complete diagnosis.

First doctors have to rule out regular cystitis, unusual bacterial causes (such as tuberculosis, parasites and chlamydia), kidney malfunctioning and neurological diseases (such as multiple sclerosis) which could affect the bladder, and bladder cancer, particularly in men, where bladder cancer is more common.

If a cystoscope with a fiber-optic attachment used to view the interior of the bladder does not show any disease under local anesthesia, then, with the patient unconscious, doctors must fill and stretch the bladder enough to see the tiny pinpoint hemorrhages all over the bladder wall, which are the hallmark of this disease.

Decreased bladder capacity is another sign. Because of scarring, this disease can decrease the capacity to as little as three or four ounces versus the normal 12 ounces. Finally, doctors can perform a biopsy of the bladder lining and muscle. "If they see inflammations involving both, and nothing else comes up positive, then it's IC," says Hanno.

One woman in northern New York can't travel to New York City anymore because she is unable to get through the Lincoln Tunnel without needing to urinate.

The cause of IC is a subject of considerable speculation. One theory suggests that the body's own defense mechanisms are launching antibodies against the lining and muscles of the bladder, which causes them to deteriorate, says Hanno. Other theories include undiscovered infectious agents, stress, allergies, diet and drugs.

Dr. Larrian Gillespie, director of the Women's Clinic of Interstitial Cystitis in Los Angeles, believes antibiotics, when used in the absence of infection, may damage the protective membrane of the bladder surface.

Hanno is looking for a problem in the protective coating of the bladder, which, under normal conditions, protects against "acid burn" of urine and attachment of antibodies. Because of the predominance of the disease in women, he says, possible hormonal causes should not be overlooked.

Treatment is difficult, and nothing cures or reverses the disease. For some victims, pain medication, including low doses of codeine and anti-inflammatory medications, provide relief. But treatment may mean constant medication. Steroids are considered undesirable because they require large doses and produce side effects.

Doctors also can overfill the bladder under anesthesia for a few minutes to help break up scar tissue, soothe nerve endings and relieve pain.

The anti-inflammatory drug DMSO (dimethyl-sulfoxide), which has been banned by the Food and Drug Administration for other uses, was approved to treat IC in 1978. Some researchers prefer other drugs, such as applications of silver nitrate. In all treatments efforts, the results are mixed.

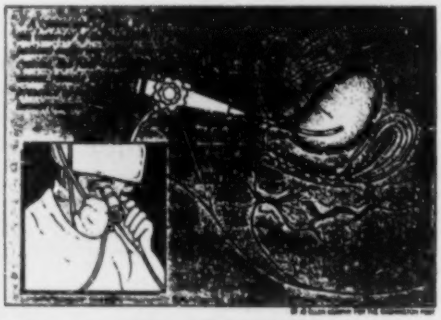
Surgical efforts to remove nerves in the bladder have not yielded good results. But surgeons can remove the diseased sections of the bladder and replace it with pieces of bowel. Because the reconstructed bladder may not function normally, patients may have to be catheterized for the rest of their lives. This approach, however, is very effective, Hanno says.

Ratner, meanwhile, still suffers from IC pain. "I always know where the nearest bathroom is," she says.

But hearing from 25,000 other victims since the spring of 1984 when she organized the Interstitial Cystitis Association has helped. Even physicians write to her for information.

"Now I know I'm not alone and I'm not crazy," she says. "This really has been a closet disease."

Janis Johnson is a free-lance writer living in Philadelphia.



Resources and Support

The Interstitial Cystitis Association was formed last year as an information and research network for a disease once lumped vaguely with other ailments as an "urethral syndrome."

A medical advisory board, headed by Dr. Thomas Stamey, chairman of urology at Stanford University Medical Center, is updating medical information available to physicians. Written material for patients, describing symptoms, diagnosis and possible treatment, is also available.

The association is organizing local support groups. And a list of doctors willing to try to help IC victims is being compiled so sufferers can avoid going from physician to physician without results.

For more information, write the Interstitial Cystitis Association, P.O. Box 4178, Great Neck, N.Y., 11027, or P.O. Box 151323, San Diego, Calif., 92115.

Mr. **Natcher**. Thank you very much, Doctor. You are the first witness to appear before our subcommittee in regard to IC. We want you to know that we appreciate your appearance. I just said to Mr. Neil, I want him to contact Dr. Wyngaarden and find out where we are as far as NIH is concerned in regard to IC, and to furnish us a statement before we mark this bill up.

You know, Doctor, as the members of this subcommittee have heard me say on more than one occasion, after we finish our Department witnesses for the Department of Labor, Department of Health and Human Services, and the Department of Education and for the related agencies, have outside witnesses.

And Doctor, we are very much concerned about what the outside witnesses say to us. We are concerned about your testimony. We have witnesses that travel thousands of miles to appear to testify before our committee, and it helps us.

On this bill, Doctor, and I say this to you quite frankly, we need all the help we can get. This bill is a large bill, money-wise, and it is the most important appropriation bill as far as the people are concerned.

We are very much concerned about all of these matters, and I say to you again, we appreciate your appearance, and especially since this is the first time it has been called to the attention of the subcommittee by a witness.

Thank you very much.

Dr. **Ratner**. Thank you very much.

Mr. **Early**. Mr. Chairman, may I ask one question? Doctor, I can't understand why, from your testimony, you say it is difficult to diagnosis this disease. Wouldn't the physician just go into the medical library, punch the information in his computer, and come back with the answer?

Dr. **Ratner**. Most patients with those symptoms have a simple urinary tract infection. Generally, men don't have that problem as frequently as women, so they culture bacteria in the women and give them antibiotics, but the literature until recently said it was a female ailment in post-menopausal women.

We are seeing this disease in children, young adults, and it is a very large span of age, a controversial disease, so little known about it, and only over the past few years, through the efforts of our organization working with many medical centers to get the publicity and educate the urologists as well as patients.

It wasn't until a year ago that the chapter was rewritten in the standard urology texts.

Mr. **Early**. That is disturbing. Is the frequency 365 days a year?

Dr. **Ratner**. It varies, some patients have waxing and waning symptoms. Some patients, it is constant.

Mr. **Early**. If you didn't take the time and spend your money to come down, we never would have heard anything about this.

Mr. **Natcher**. Doctor, thank you again very much. We appreciate your appearance.

Dr. **Ratner**. Okay.

Mr. **Natcher**. The committee will now recess until 2:00 this afternoon.

[The following additional information was submitted:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland ~~20205~~
20892

MAY 19 1986

The Honorable William H. Natcher
House of Representatives
Washington, D.C. 20515

Dear Mr. Natcher:

Enclosed, as requested, is a report on the National Institute of Diabetes and Digestive and Kidney Diseases activities on research related to interstitial cystitis.

Sincerely yours,

James B. Wyngaarden

James B. Wyngaarden, M.D.
Director

Enclosure

REPORT ON RESEARCH RELATED TO INTERSTITIAL CYSTITIS SUPPORTED BY THE NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

INTRODUCTION

The following report is submitted in response to a request from the House Appropriations Committee concerning research related to interstitial cystitis supported by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

BACKGROUND

Interstitial cystitis is a collective term for a group of chronic, unexplained, irritative bladder conditions resulting in multiple, frequent, and painful voidings. This condition results in scarring and stiffening of the bladder wall. Patients have a decreased bladder capacity, resulting in a constant and urgent need to urinate. The pain is severe, chronic, and debilitating. The epidemiology of interstitial cystitis suggests that it occurs most often in adult women; however, it has also been reported in children.

It is generally recognized that interstitial cystitis is extremely difficult to diagnose. According to leading urologists, however, the following factors must be documented before a diagnosis of interstitial cystitis can be made:

- Chronic, unexplained irritation with urination.
- Urine cultures negative for bacteria.
- Small hemorrhages throughout the inside of the bladder wall, observed by cystoscopy, a procedure for examining the inside of the bladder.

Urologists specializing in interstitial cystitis emphasize that it is essential that cystoscopic criteria be followed in diagnosing the condition.

Practicing urologists also report that traditional therapy for this condition has been clinically and scientifically unsatisfactory, largely because the basic pathophysiologic mechanism is unknown.

Research to date has not uncovered the etiology of interstitial cystitis, although the possible roles of bacterial, viral, fungal, inflammatory, and immune mechanisms have been studied. Basic research on urinary tract physiology and pathophysiology is thus considered essential to the task of developing a better scientific understanding of interstitial cystitis.

CURRENT RESEARCH AND TREATMENT

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) leads and coordinates Federal research in kidney and urinary tract disorders. The Urology Program of this Institute supports a substantial amount of research on the physiology and pathophysiology of the urinary tract, on bladder dysfunction, and on urinary tract infection. This Program expends approximately $6 million annually on urological research.

NIDDK recognizes the need for increased research to determine the cause and treatment of interstitial cystitis, and is actively encouraging scientific investigators to apply to NIH for research grants in this area. Research supported by NIH is primarily investigator-initiated, that is, the investigator develops an idea for a research project and submits a proposal to NIH for funding. Applications compete for available funds through the rigorous NIH two-tiered peer review system, which identifies those applications judged to be of the highest scientific merit, technical feasibility, and program relevance. Highly promising investigative initiatives on the causes or the clinical management of interstitial cystitis have been lacking.

A number of important research avenues that can contribute to developing an understanding of interstitial cystitis are currently being pursued by NIDDK grantees, including studies on various aspects of urinary tract function; investigations of the autonomic control of the bladder; development of an instrument to measure bladder volume; and research on growth, differentiation, and function of the epithelium of the urinary bladder. Other research in this area, not directly supported by NIDDK, includes a clinical trial of the experimental drug sodium pentosanpolysulfate (Elmiron) as a possible treatment for interstitial cystitis.

FUTURE RESEARCH DIRECTIONS IN INTERSTITIAL CYSTITIS

The Institute understands the concern of patients with interstitial cystitis and their families. The painful and debilitating nature of this condition make it a difficult and important disease. NIDDK shares the frustration that definitive causes and treatments have not yet been found.

Development of an effective treatment for interstitial cystitis will be largely dependent upon generating a solid scientific understanding of the urinary tract in normal and diseased states. Recent experience with a major breakthrough in understanding another disease of the urinary tract, polycystic kidney disease (PKD), points out how basic research can be the foundation of clinical advances. The cause of PKD had been unidentified until recently, when a molecular biologist--working on a research project with no direct relevance to PKD--was able to pinpoint the defect in PKD to a specific chromosome. This finding enabled the development of a diagnostic test to determine not only individuals affected, but also those unaffected. Now, for the first time, there is a real possibility of preventing one of the major causes of chronic renal disease.

The Institute is seeking to encourage biomedical investigators to pursue a number of research opportunities related to interstitial cystitis:

- o While evidence to date indicates the condition does not have an infectious etiology, this has been determined primarily by standard techniques. This does not, however, rule out identification of an infection which might require exposure to cultured bladder cells of specific types or other unique conditions for identification. These caveats apply to both bacterial and viral agents.

- Since interstitial cystitis has been described in patients with systemic lupus erythematosus, some have suggested that it may have an immune component. However, evidence to date does not point to an autoimmune response since lymphocytic infiltrates and depositions of immunoglobulins are not regularly observed. Mast cells have been found. These studies are relatively rudimentary and more sophisticated research methodologies should be applied to determine whether there is an underlying immune response in this condition, particularly the precise roles of cellular and humoral immunity.

- Basic cell biology studies should be initiated to isolate and characterize the cell types of the lower urinary tract, including the bladder and urethra. Specific studies that could be undertaken include identifying specific biochemical defects (abnormal mucus products, for example) or the presence of specific toxins in the urine of patients with interstitial cystitis.

Institute staff have already taken a number of initiatives over the past year to encourage additional research on interstitial cystitis. These include:

- Meeting with groups of investigators interested in the lower urinary tract, including Dr. Alan Wein, Chairman, Division of Urology, University of Pennsylvania, a leading investigator in bladder function, regarding the causes of interstitial cystitis and current research approaches.

- Consulting at the American Urological Association meeting with leading urologists regarding strategies for studying interstitial cystitis.

- Planning a meeting for FY 1987 to focus on defining the research questions in this area, with the goal of developing a Program Announcement to encourage researchers to study interstitial cystitis.

- Seeking the advice of knowledgeable experts in interstitial cystitis on development of a research strategy. These experts, including E. Darracott Vaughn, Jr., M.D., the Chairman of the Research Committee of the American Urological Association, have been in agreement with the NIDDK research approach. At this stage of scientific understanding about the disease, NIDDK recognizes the urgency of the disease clinically, and is fostering basic research applications that may provide the necessary tools to develop a sound clinical approach.

NIDDK PLANS RELATED TO INTERSTITIAL CYSTITIS

As noted previously, NIDDK is planning a workshop to bring together clinicians with an interest in bladder physiology, researchers with expertise in infectious etiology of disease, immunologists, and cell biologists. In addition, the Institute intends to invite representatives from the interstitial cystitis health voluntary community to participate in its planning and to attend this workshop.

One goal of the workshop is to share information on current knowledge of this condition, and to seek guidance on useful directions for research. It is clear that a critical first step is establishing uniform diagnostic criteria that will be clinically accepted. It is also important that epidemiologists become involved in these studies, as definitive epidemiologic data are currently lacking. Finally, a number of therapies have been tried, many quite painful, and none totally successful. Guidance will be sought from workshop participants on strategies to address these needs.

SUMMARY

The NIDDK hopes that the workshop and other staff initiatives will lead to a research strategy for combating interstitial cystitis. The ultimate goal of the Institute is to increase understanding of interstitial cystitis and to develop an effective treatment to end the pain and debilitation experienced by patients.

AFTERNOON SESSION

WEDNESDAY, MAY 7, 1986.

ALZHEIMER'S DISEASE RESEARCH

WITNESS

MRS. DONALD McGANNON, MEMBER, BOARD OF DIRECTORS, ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION

Mr. NATCHER. Our first witness this afternoon is Mrs. Donald McGannon. It is a pleasure to have you before the committee, and we will be pleased to hear from you.

Mrs. McGANNON. Mr. Chairman and members of the subcommittee, good afternoon.

I am Mrs. Donald McGannon and I am here on behalf of ADRDA, the Alzheimer's Disease and Related Disorders Association.

Mr. Chairman, I am here because I have a deep personal interest in seeing that one day soon, we are rid of this horrible disease known as Alzheimer's disease.

My concern stems from the fact that my husband Donald, an otherwise brilliant, dynamic and healthy man, died of this disease just two years ago at the age of 63.

As you know many, he had been Chairman of Group W, Westinghouse Broadcasting and Cable, Incorporated and was viewed by his peers as a pioneer in that industry.

His passing as a result of Alzheimer's disease left a void, with his family of 13 children, his colleagues and his friends, that only served to underscore the fact that none of us is immune to this devastating problem. But perhaps those he left behind can in our own way, continue to make the world a better place by conquering Alzheimer's disease.

By way of background, Mr. Chairman, our Association was established in 1979 by the families and loved ones of Alzheimer's patients. Since that time, our organization has grown from a handful of family members into a network of over 140 chapters and more than 360 family support groups throughout the country.

Through this period of growth, our mission has remained the same, to help support and assist those unfortunate families who are struggling to cope with Alzheimer's disease.

Mr. Chairman, the first time Alzheimer's disease was addressed at the national level came as a result of actions taken by this subcommittee in 1981. ADRDA's President, Jerome Stone, became familiar with AD because his wife was a victim of this awful illness for 15 years.

In 1981, he testified that government had for too long ignored this disease and the tremendous physical, emotional and financial hardship it creates. Since Mrs. Stone's death in 1983, Mr. Stone's dedication to wiping out this disease has continued on behalf of those 2,500,000 Americans who are still trying to cope.

At this subcommittee's insistence, the level of research support has grown steadily. This in turn has led to a 10-fold increase in the number of scientists studying this disease. But, most importantly, what you have done is to lay the groundwork for some very promising new research.

As Dr. Williams, the head of the Aging Institute, recently testified, progress is being made on all fronts. Most recently, for example, scientists have begun to suspect that the symptoms of AD can be associated with the loss of certain clusters of brain cells.

This could suggest that relatively normal brain function might be restored if the damaged brain areas could somehow be compensated for or replaced.

Also, a little over two weeks ago at the Einstein College of Medicine, under the leadership of Dr. Peter Davies, there occurred a new and exciting discovery of an additional protein, called ALZ-50, in the brains of Alzheimer's patients. This may be the breakthrough for one of the possible causes of Alzheimer's disease.

Still, Mr. Chairman, there is much to learn before we have the cause, treatment and cure for AD. That is why we are here again this year, asking that you continue to support basic medical research in this area.

Specifically, we respectfully urge you to provide a minimum of $75,000,000 to support research at NIH and NIMH. We also ask that you provide an additional $2,000,000 needed to support the 10 research centers that are now in operation.

We realize that this is a difficult year, but we hope you will weigh the long-term benefits of establishing two new centers.

As I indicated earlier, our Association's mission is to help families that are confronting the day-to-day anguish of caring for an Alzheimer's patient. While science looks to the future for a cause and cure, we strive to ease the overwhelming burden that is placed on families and caregivers.

But our efforts alone are not enough, Mr. Chairman. Families are in desperate need of a wide range of services, including respite care, adult day care, transportation, administrative and legal assistance and in in-home personal and medical services.

The costs at nursing facilities are prohibitively high for two reasons.

One, the steadily increasing frequency with which Alzheimer's is diagnosed in the American population taxes the current number of nursing professionals; and, two, the special nature of Alzheimer's disease which requires constant supervision and stimulation for its patients. This level of care is a full-time job for any nursing home staff member.

As you know, neither medicare nor most insurance plans cover Alzheimer's disease and what little help medicaid offers comes only after family resources are all but depleted. By that time, society has two victims on its hands: The patient and the caregiver.

Under the circumstances, we ask the subcommittee once again to take the leadership role by directing the appropriate Federal agencies, such as the Administration on Aging, to target greater resources on helping Alzheimer's families.

To conclude, we recognize that government alone cannot eliminate the suffering caused by Alzheimer's disease. But by working together, our national association, industry, labor, and government at all levels, perhaps we can ease the burden on patients and their families until a cure is found.

For the record, Mr. Chairman, I would like to submit a copy of ADRDA's national program to conquer Alzheimer's disease.

Thank you.

[The statement of Mrs. McGannon follows:]

TESTIMONY PRESENTED BY

MRS. DONALD McGANNON

MEMBER, BOARD OF DIRECTORS

of the

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION

to the

HOUSE LABOR/HHS/EDUCATION SUBCOMMITTEE ON APPROPRAITIONS

MAY 7, 1986 2:00 PM

(Subject: Research and Family Service Needs

of Alzheimer's Families)

Mr. Chairman and members of the Subcommittee-

I am Mrs. Donald McGannon and I am here on behalf of ADRDA, the Alzheimer's Disease and Related Disorders Association.

The fact is, Mr. Chairman, I am here because I have a deep personal interest in seeing that one day soon we are rid of this horrible illness known as Alzheimer's disease. My concern stems from the fact that my husband Donald, an otherwise brilliant, dynamic, and healthy man, died of this disease two years ago. As you may know, he had been chairman of Group W Westinghouse Broadcasting and Cable Incorporated, and was viewed by his peers as a pioneer in that industry.

His passing left a void--with his family, his colleagues, and his friends--that only served to underscore the fact that none of us are immune to this devastating problem. But perhaps those of us he left behind, in our own way, can carry on his struggle to conquer Alzheimer's disease.

In the way of background, Mr. Chairman, our Association was established back in 1979 by the families and loved ones of Alzheimer's victims. Since that time, our organization has grown from a handful of family members into a network of over 140 chapters and more than 360 family support groups throughout the country. But despite that growth, Mr. Chairman, our mission has remained the same: to help support and assist those unfortunate families that are struggling to cope with Alzheimer's disease.

Mr. Chairman, the first time that Alzheimer's disease was addressed at the national level came as a result of actions taken by this subcommittee, back in 1981. At that time, the President of our Association, Jerome Stone, testified that government had for too long ignored this horrible disease and the tremendous physical, emotional, and financial hardships it creates. Since then, his burden has been lifted and the torment he described as an endless funeral has ceased. Unfortunately, for the families of more than 2.5 Americans, the struggle with Alzheimer's disease continues.

Nevertheless, I want to thank you and your distinguished colleagues for your leadership and support in the battle to conquer this horrible disease. Thank you, as well, for the added measure of hope you have given those who, until recently, saw no reason to hope.

At this subcommittee's insistence, the level of research support has grown steadily. This, in turn, has led to a tenfold increase in the number of scientists studying this disease. But most importantly, what you have done is to lay the groundwork for some very promising new research. As Dr.

Williams, the head of the Aging Institute recently testified, progress is being made on many fronts. Most recently, for example, scientists have begun to suspect that the symptoms of Alzheimer's disease can be associated with the loss of specific populations of brain cells. This could suggest that relatively normal brain function might be restored if the damaged brain areas could somehow be compensated for or replaced.

Still, Mr. Chairman, there is much to learn before we have a cure or adequate treatment for Alzheimer's. That is why we are here again this year asking that you continue to support basic medical research in this area.

Specifically, we respectfully urge you to provide a minimum of $75 million to support research at NIH and NIMH. We also ask that you provide an additional $2 million needed to support the ten research centers that are now in operation. And although we know that this is a difficult year, we hope you will weigh the long term benefits of establishing two new centers.

Mr. Chairman, as I indicated earlier, our Association's mission is to help families that are confronting the day-to-day struggle associated with caring for an Alzheimer's victim. While science looks to the future for a cure, we strive to ease the awesome burden that is placed on families and care givers.

But peer support is not enough, Mr. Chairman. Families are in desperate need of a wide range of services, including respite care, adult day care, transportation, administrative and legal assistance, and in-home personal and medical services.

As you know, neither Medicare nor most private insurance plans cover Alzheimer's disease. And what little help Medicaid offers, comes only after family resources are all but depleted. By that time, the society has two victims on its hands--the patient and the family member.

Under the circumstances, we ask that this subcommittee once again take a leadership role by directing the appropriate federal agencies, such as the Administration on Aging, to target greater resources on helping Alzheimer's families.

To conclude, we recognize that government alone cannot eliminate the suffering caused by Alzheimer's disease. But by working together--our national association, industry, labor, and government at all levels--perhaps we can ease the burden on patients and their families until a cure is found.

For the record, Mr. Chairman, I would like to submit a copy of ADRDA's National Program to Conquer Alzheimer's Disease.

Thank you.

National Program to Conquer Alzheimer's Disease

Submitted by the

Alzheimer's Disease and Related Disorders Association

April 1986

"For more than two million Americans with Alzheimer's disease, each day is fraught with fear and frustration. Fear of getting lost in one's own neighborhood; of not recognizing members of one's immediate family; of not being able to perform simple, familiar chores.

"...But until a way to prevent Alzheimer's disease is found, these families need our support and understanding."

-- President Ronald Reagan on
proclaiming November as National
Alzheimer's Disease Awareness
Month; November 8, 1985.

INTRODUCTION

Based on his study of the world's great civilizations, the historian Toynbee concluded that a society's quality and durability can best be measured "by the respect and care given its elderly citizens." That being the case, never before has the measure of this country's commitment to the elderly been so critically important.

The challenges ahead

The rapid increase in the elderly population has given rise to a host of medical, economic, and social challenges which, if left unanswered, threaten a hemorrhaging in our society. And nowhere are those challenges more evident or more threatening than for the families and loved ones of the more than 2.5 million persons now suffering from a deadly neurological disorder known as Alzheimer's disease.

A national association responds

From the time the Alzheimer's Disease and Related Disorders Association (ADRDA) was first created in late 1979, the families, care givers, health professionals, and scientists who make up the organization have strived to mount a national effort to combat this dread disease. That effort includes:

* RESEARCH aimed at finding the cause and cure for Alzheimer's disease

* EDUCATION of the general public, health professionals, and care givers

* CHAPTER formation of a nationwide family support network

* ADVOCACY of essentially-needed government assistance

* and PATIENT and FAMILY SERVICES

In furtherance of these goals, the ADRDA submits the following National Program intended to serve as a guide in helping to meet some of the challenges brought on by Alzheimer's disease.

The growing threat of Alzheimer's disease

Medical researchers have established that Alzheimer's disease, the most widespread form of dementia disorders, is not simply a part of the aging process -- as evidenced by the fact that many of its victims are in their forties and fifties. Yet for some reason the vast majority of Alzheimer's sufferers are elderly persons.

According to the U.S. Public Health Service, Alzheimer's disease affects at least one person in twenty between the ages of 65 and 75, and every fifth person over 80 years of age. It follows, therefore, that as the number of elderly persons grows society can expect to encounter a substantial increase in the incidence of Alzheimer's disease and related disorders.* Apart from causing widespread human suffering, the disease will then carry particularly severe social and economic implications, as families, health professionals, and institutions are strained far beyond their limits.

Of course, from a public health perspective there can be no doubt that Alzheimer's disease has already reached epidemic proportions.

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*Today, the elderly constitute about 11 percent of the total U.S. population. By the year 2030, the Bureau of the Census projects that 21 percent of the population, 64.5 million persons, will be age 65 and older. Nearly half of that total will be over age 75.

EXPANDING SUPPORT FOR MEDICAL RESEARCH

> "The tacit assumption in our society that everyone will eventually become "senile" must be put aside. The expected norm should be that of a vigorous, intellectually active aging process."
>
> --Dr. Robert Katzman
> Professor and Chair, Department of Neurosciences, University of California at San Diego

Eighty years have elapsed since a German neurologist named Alois Alzheimer first described the effects of a progressive fatal dementia on a 51-year old patient. But it is only in the past decade that the disease which bears his name has received major research attention. Since 1976, research funding provided through the National Institutes of Health has increased from $4 million to nearly $50 million annually. Over the same period, the number of scientists studying the disease in the U.S. has jumped at least tenfold.

With greater federal involvement and increased scientific interest have come promising new research findings. One of the major advances over the past decade was the discovery that Alzheimer's patients often suffer from certain biochemical abnormalities in the brain. Most strikingly, they lack an enzyme that helps produce an important chemical messenger, or neurotransmitter, involved in learning and memory. In other studies, scientists have discovered similarities in protein fragments found in the damaged areas of the brain and in the brain's blood vessels, suggesting that perhaps science is moving closer to finding the underlying cause of Alzheimer's disease.

More recently, scientists have begun to suspect that the symptoms of Alzheimer's disease can be associated with loss of specific populations of brain cells. This finding could suggest that relatively normal brain function might be restored if the function of the damaged brain areas could be compensated for or replaced.

But in spite of this remarkable progress, as one government publication describes it, a diagnosis of Alzheimer's disease "carries with it a sentence of eventual mental emptiness."

In other words, there is still much to be done. For while new knowledge is helping to reduce the degree of impairment of Alzheimer's victims, science is still unable to prevent the disease, cure it, or stop its progression. And although research funding has increased in recent years, the total spent on finding a cause or cure still amounts to less than one-tenth of one percent of the $32 billion spent annually to care for victims of Alzheimer's disease.

Recommendations:

* That federal support for research on Alzheimer's disease be assigned a high priority at the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Allergy and Infectious Diseases.

* That funding for research on Alzheimer's disease be increased to at least $75 million in fiscal year 1987.

STRENGTHENING ALZHEIMER'S DISEASE CENTERS

> "Full support of the Alzheimer's disease centers program is a crucial element in this war. In good conscience, we cannot recruit a cadre of scientific soldiers and send them into battle without the ammunition they need to keep fighting."
>
> --Dr. David Drachman, Professor
> and Chair of Neurology at
> the University of Massachusetts
> Medical School.

From a scientific standpoint, there are a number of issues surrounding Alzheimer's disease that must to be addressed, not the least of which is finding a clinical diagnostic procedure for identifying Alzheimer's patients. Recognizing that a mechanism was needed that would address several of these problems simultaneously, two years ago Congress and the President launched a new and innovative effort designed to complement the work being conducted by independent researchers.

Since 1984, ten Alzheimer's research centers have been established -- each having clinical demonstration units together with a staff of investigators drawn from various scientific disciplines. As required by Congress, the ten centers are administered by the National Institute on Aging, working in cooperation with the National Institute of Neurological and Communicative Disorders and Stroke, the National Institute of Mental Health, and the National Institute of Allergy and Infectious Diseases.

The ten existing centers have already begun to have a dramatic impact on the status of research into Alzheimer's disease. As a result of the centers program, for example, a network of over 100 scientists throughout the country have begun to work together, sharing ideas, knowledge, and resources. Among other things, the participating scientists have already begun to standardize the diagnostic instruments used in identifying Alzheimer's disease.

Unfortunately, budget cutbacks threaten to weaken the centers program and slow the pace of scientific advances -- at a time when promising research leads point to the need for a stronger commitment to this effort. Additional funding in the amount of $2 million is required simply to maintain the basic centers program. Beyond that, an additional $5 million would permit the ten centers to expand clinical data gathering activities and support work on new and emerging research leads.

Recommendations:

* That an additional $2 million be provided in fiscal year 1987 to more adequately support the activities of the ten existing research centers.

* That an additional $5 million be provided to expand both basic research projects and clinical activities.

* That an additional $2.2 million be appropriated to support the establishment of two new research centers.

PROVIDING FAMILY SUPPORT SERVICES

According to the National Center for Health Statistics, over eighty percent of all home care is provided to the chronically ill elderly by family members. For the families of Alzheimer's victims, this usually entails mobility assistance, personal care, and household assistance.

Apart from placing an enormous financial burden on families, meeting the extensive needs of an Alzheimer's victim often results in severe stress and family dysfunction, manifested as physical illness, anxiety, depression, and family conflict. This is due, in large part, to the fact that Alzheimer's disease usually runs an agonizingly slow course, lasting anywhere from five to twenty years. Recognition of this fact has led to the development of programs designed to help ease the burden on caregivers; foremost among these has been the development of an extensive family support network by the Alzheimer's Disease and Related Disorders Association.

But peer support is clearly not enough. Family caregivers are in desperate need of a wide range of services, including respite care, adult day care, transportation, administrative and legal assistance, and in-home personal and medical services.

Recommendations:

* That the federal government forge a partnership with state and local agencies to launch a nationwide effort to help meet the needs of families caring for Alzheimer's victims. In so doing, government agencies at all levels should draw upon the knowledge and expertise of the Alzheimer's Disease and Related Disorders Association.

* That the Administration on Aging be directed to support exemplary projects to serve as models for rendering family support services. To the extent feasible, this effort should be carried out through a partnership arrangement with national voluntary organizations, such as the Alzheimer's Disease and Related Disorders Association.

* That the federal government offer subsidized loans to public and private nonprofit institutions to finance the development of respite care programs and adult day care centers for Alzheimer's victims and their families.

* That the National Institute of Mental Health continue its research on the family stress problems related to the care of Alzheimer's victims.

MEETING THE COSTS OF LONG-TERM CARE

Long-term care is, of course, a growing national concern. In his most recent State of the Union Address to Congress, President Reagan focused attention on the fact that "devastating illness can destroy the financial security of a family."

Nowhere is that more evident than with families struggling to cope with Alzheimer's disease, for the nature of this illness is such that the long-term care needs of its victims most often arise at a time when the family's economic and social resources -- including savings, pensions, and other assets -- are dwindling. Furthermore, the care and treatment of Alzheimer's patients is deemed "custodial" and specifically excluded from coverage under Medicare and practically all private health insurance plans. Consequently, the catastrophic costs of caring for an Alzheimer's victim are borne almost entirely by their families. And while Medicaid offers some help, this program most often favors institutionalization -- and is available only after a family has exhausted nearly all of its resources. (Of course, all of these problems are more pronounced when victims have no family or loved ones to turn to for help and support.)

To further compound the problem, families of Alzheimer's victims frequently encounter difficulties in obtaining access to nursing home care, since many facilities prefer short-stay, Medicare or privately-insured patients.

Recommendations:

* Federal policies should be developed which stimulate a broader range of alternative programs and services. To this end, Medicare coverage should be extended to victims of Alzheimer's disease; the Secretary of HHS should be directed to authorize Medicare waivers and home health care for these individuals.

* Far more emphasis (and resources) should be devoted to health services research on alternative delivery systems. A major portion of this research ought to be focused on developing an intergrated continuum of care, including cost-effective strategies for expanding community-based care and in-home services.

* Federal statutes should expressly prohibit nursing homes from discriminating in the acceptance or refusal of individuals as patients on the grounds that those individuals are on Medicaid or are victims of Alzheimer's disease.

* Families and care givers should be allowed a tax deduction or refundable tax credit to help defray the added costs associated with caring for an Alzheimer's victim at home.

* Any federal and/or private initiative to address the need for catastrophic or chronic illness insurance should include coverage for victims of Alzheimer's disease.

ENSURING EQUITABLE TREATMENT UNDER FEDERAL DISABLILITY PROGRAMS

The Social Security Administration has national responsibilty for the administration of both the Social Security Disability program and the Supplemental Security Income (SSI) program. The former provides cash benefits to those disabled workers and their dependents who have contributed to the social security trust fund; the latter provides for a minimum income level for the needy aged, blind, and disabled who qualify because of financial need. Under both programs, the definition of disability is the same: "an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." (The decision as to whether an applicant is disabled, as defined by law, is made by a special disability determination unit in each state.)

Although federal statutes do not preclude benefit payments to Alzheimer's victims, the guidelines used to determine eligibility are rather vague when it comes to this disease. This, in turn, has led to wide variations from region to region, resulting in an uneven policy toward individuals who hold a rightful claim to benefits.

Recommendations:

- Federal regulations and guidelines used in evaluating disability claims should be amended to include specific reference to Alzheimer's disease and related disorders.

- A mechanism should be established whereby the most current scientific knowledge available to the National Institutes of Health is communicated to those responsible for overseeing and administering disability programs.

- Government agencies, working together with the medical and scientific community and ADRDA, should devise specific assessment tools for use by examining physicians.

ESTABLISHING A CONSISTENT POLICY FOR VETERANS WITH ALZHEIMER'S DISEASE

The Veterans' Administration currently has no uniform nationwide policy regarding the care of veterans with Alzheimer's disease. As a consequence, some victims of the disease are admitted for treatment at VA medical facilities, while others are denied admission or referred elsewhere. In other instances, patients are being forced to leave VA facilities, thereby disrupting their care and placing even greater strain on families.

Recommendations:

* The VA should develop a fair and consistent policy with respect to the care and treatment of Alzheimer's victims. That policy, in the form of written guidelines, should be distributed to VA installations throughout the country.

* Local VA facilities should be instructed to develop and implement screening, couseling, and treatment programs for veterans and their families.

* The eligibility requirements for veterans diagnosed as having Alzheimer's disease should be lowered to age 50.

* A portion of VA intermediate-care hospital beds, perhaps ten percent, should be set aside for the care of veterans suffering from Alzheimer's disease and related organic brain disorders.

* The VA should institute a system of enrollment and tracking to permit greater coordination of inpatient care and community-based services.

* Pilot studies and/or model projects undertaken by the VA should take into account the special needs of veterans suffering from Alzheimer's disease.

MEETING TRAINING AND EDUCATION NEEDS

> "To the extent that individuals can be trained to help themselves and contribute to society, they preserve their autonomy and morale and they free formal and informal providers for other productive activities."
>
> -Dr. Robert N. Butler
> Professor of Geriatrics,
> Mount Sinai School of
> Medicine

Despite a growing awareness of the extent and burden of dementias such as Alzheimer's disease, there still exists a serious shortage of trained personnel, including research investigators, hospital and nursing home staff, safety and transportation personnel, home health aides, and family members.

Recommendations:

* Greater emphasis should be placed on career development of faculty and research investigators. As part of this effort, NIH should (1) expand the number of National Research Service Awards in the field of neuroscience, with particular emphasis on Alzheimer's disease and (2) strengthen the training component of the specialized Alzheimer's research centers.

* Clinical training needs must be re-evaluated in light of new research findings. Specifically:

  - New training curriculum must be developed which targets on treating persons with Alzheimer's disease; special attention should be paid to basic training (and continuing education) for clinical care providers

  - The Secretary of HHS should institute special training programs aimed at nursing home personnel, home health aides, pathologists, medical examiners, safety and transportation personnel, and families.

* Special emphasis should also be placed on the needs of special populations, such as minorities and the frail elderly.

PROMOTING COORDINATION AND PUBLIC AWARENESS

The fundamental need exists for greater cooperation and coordination among the several research institutions, health care providers, and families now engaged in one facet or another of this national problem. Furthermore, greater public awareness is essential if society hopes to overcome the growing challenge of Alzheimer's disease.

Recommendations:

* A national advisory council should be established to help develop, encourage, and guide research on Alzheimer's disease, as well as to serve as a mechanism for conveying new information and ideas to physicians, nurses, care givers, and family members. The council, with the full support of federal agencies, should promote collaborative efforts among those agencies, university research centers, pharmaceutical houses, and others throughout the medical and scientific community.

* The council, as well as key federal, state, and local agencies should utililize the knowledge and expertise of the Alzheimer's Disease and Related Disorders Association.

Mr. **Natcher**. Thank you very much. We appreciate your statement.

Mr. Conte, I yield.

Mr. **Conte**. I want to join you in welcoming Mrs. McGannon to our Committee, and to thank her for her very fine statement. Her husband was a great man, and one of the great pioneers in broadcasting.

Mr. **Natcher**. Thank you very much.

Wednesday, May 7, 1986.

ALZHEIMER'S DISEASE RESEARCH

WITNESSES

HON. WILLIAM LEHMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

SHIRLEY FIRSCHEIN, EXECUTIVE VICE PRESIDENT, ALZHEIMER'S DISEASE AND RELATED DISORDERS OF GREATER MIAMI

Mr. **Natcher**. We have with us our friend and colleague from Florida, Mr. William Lehman, who is also a member of our full Committee on Appropriations, and the chairman of the Subcommittee on Transportation, and one of the able members of the House.

Mr. Lehman, we want to hear from you, and I believe you want to present our next witness.

Mr. **Lehman**. Thank you, Mr. Chairman.

I have Mrs. Shirley Firschein to introduce. She happens to reside in Senator Pepper's District. I have a letter from Senator Pepper introducing her to the committee, and I will file it for the record. Senator Pepper indicates his strong support for her endeavors, and he details her contribution to the battle against Alzheimer's disease.

It is also a privilege to introduce Mrs. Firschein, because of my personal friendship with her. I would like to file my own introduction for the record.

I have been in touch with her from month to month, and I know the ordeal she and her family have been through. I think that someone who has lived with this problem as she has can certainly be a valuable witness to this committee.

Thank you, Mr. Chairman.

[The information follows:]

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18TH DISTRICT, FLORIDA

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COMMITTEE ON RULES

SELECT COMMITTEE ON AGING
CHAIRMAN
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MARIA SOMELLAN
LATIN REPRESENTATIVE

May 7, 1986

Chairman
Subcommittee on Labor/HHS Appropriations

Dear Mr. Chairman:

I had looked forward to the pleasure of introducing to your distinguished subcommittee this afternoon Mrs. Shirley Firschein, who is the Executive Vice President of the Alzheimer's Disease and Related Disorders of Greater Miami. Mrs. Firschein will give her personal experiences as the wife of a husband who has Alzheimer's disease. She has been through all of the demanding experiences of an intimate member of the family who has Alzheimer's disease during the course of that terrible disorder. Mrs. Firschein has has great experience in the area of those afflicted with Alzheimer's disease because it is estimated that over 60,000 people who are the victims of Alzheimer's disease reside in Dade County, the home of Mrs. Firschein. Mrs. Firschein is a lady of great compassion, of outstanding ability, and the deepest dedication to the needs of those who are the victims of Alzheimer's disease.

I regret exceedingly that I am having to chair at this hour a meeting of the Rules Committee on important legislation and will not have the pleasure of personally presenting Mrs. Firschein to you. I would be grateful, Mr. Chairman, if you will read this little note from me as my introduction of Mrs. Firschein. Thank you very much.

Sincerely yours,

Claude

Claude Pepper
Member of Congress

WILLIAM LEHMAN
17TH DISTRICT, FLORIDA

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Introduction of Mrs. Shirley Firschein
before the Labor-HHS Appropriations Subcommittee

Mr. Chairman, I have the privilege today of introducing Mrs. Shirley Firschein, the Executive Vice President of Alzheimer's Disease and Related Disorders of Greater Miami.

Mrs. Firschein has been tireless in her efforts to educate and inform people about the tragic disease of Alzheimer's, and I know that you will find her personal testimony very helpful today.

Thank you.

William Lehman
Member of Congress

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

Mr. **Natcher.** Thank you very much, Mr. Lehman.

Mrs. **Firschein.** Mr. Chairman, members of this committee, my name is Shirley Firschein. I am Executive Vice President of the Alzheimer's Disease and Related Disorders of Greater Miami.

The Greater Miami area is unique in comparison to any other city in the Nation. We have the largest population of elderly and one of the highest concentration of patients with Alzheimer's disease.

At present, it is estimated that over 60,000 people with Alzheimer's reside in Dade County. Who better can describe the tremendous stress of coping, and the economic drain on families, than someone such as I, who has experienced them?

Mr. Chairman, I cannot adequately relate the tragic impact I have had to endure. My husband, a victim of Alzheimer's disease, just passed away. In the years while he was in a skilled nursing center, he had been a victim of brain surgery, two pneumonias, three bilateral pneumonias, scores of staph infections, fractures, strokes, bed sores and finally a leg amputation.

I was a residual victim. During these critical years, I experienced a tremendous feeling of helpless suffering and sorrow watching him slowly die, compounded doubly because I have a teenage daughter who also had to cope.

At an early age, when she should have been enjoying life at its fullest, she was trapped in the same box as my husband and I. Trapped in a box called Alzheimer's disease.

Mr. Chairman, thinking back through those horrible years, my ordeals were nightmares. My husband was a veteran serving his country during World War II. He was also a doctor, an administrator of Bellevue Hospital and Deputy Commission of the Department of Hospitals in New York City.

When things became increasingly difficult for me, I went to the Veterans Hospital in Miami, to transfer him from the hospital he was in. After a few days of repeated attempts at the Veterans Hospital, I was told it was impossible to admit him, since they had an eight-year waiting list.

Instead, it was suggested that I bring him to the emergency room, dump him and run. That way, they would have to take him in. This episode occurred in 1981.

While in the skilled nursing facility, although my husband was immobile, restraints were used, demoralizing our family completely. He suffered terribly because of the ignorance of the highly qualified staff plus the inexperience of the staff in knowing how to handle an Alzheimer's patient.

In order to maintain his dignity, I was forced to come there every day of his life. There was no respite for me. Financially, it was just as devastating. The drain of income and principal, approximately $400,000, of the time at home until his death caused me to have many sleepless nights.

We have catastrophic coverage that should have paid for skilled nursing care, but with the diagnosis of Alzheimer's disease, he automatically fell into the category of custodial care.

The hardest thing for us was the fact that my husband required skilled nursing care from the time of his admission. Another added problem in coping was the inability of medicare to cover expenses that medicaid would have covered, primarily nursing homes.

Alzheimer's disease doesn't discriminate. If affects the rich, the middle class and the poor. We are all alike.

Mr. Chairman, in telling you about some of my stress and frustration, I speak for the many millions of Americans all over this country who are suffering emotionally, physically, mentally and financially as members of the families of an Alzheimer's patient.

Although small advances have been made, presently the need for Federal laws is vital. I know of nothing in our society today where individuals are left so unassisted and exposed to catastrophic illness as are the victims of Alzheimer's disease.

I believe it is time to address these issues so that the pain and suffering the patient and families face daily, could be eased.

Mr. Chairman, although this committee is supportive and sympathetic to our needs, the bottom line is that we must have some form of government subsidy through health services in order that proper care is given to the patient, and for the survival of the families.

By coming to terms with this problem, each and every human being could live and die with dignity.

Thank you for the opportunity to speak to this committee, Mr. Chairman. I will be happy to answer any questions.

Mr. NATCHER. Thank you very much, Mrs. Firschein. You have made an excellent statement. We appreciate your appearance before the committee.

Mrs. FIRSCHEIN. Thank you.

Mr. NATCHER. Mr. Lehman, thank you very much. You come back to see us.

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESS

DR. ALAN D. SCHREIBER, MEMBER, PUBLIC EDUCATION COMMITTEE, AMERICAN SOCIETY OF HEMATOLOGY

Mr. NATCHER. Our next witness is Dr. Alan Schreiber. Come around, Doctor, we will be pleased to hear from you at this time.

Dr. SCHREIBER. First, I would like to thank you, Mr. Natcher, and you, Mr. Conte, your long-term enthusiastic support for the NIH.

I speak for all of my colleagues at the American Society of Hematology, where we have greater than 3,000 members. As you know, our Society is the only national organization that represents physicians involved in the care of patients with blood diseases, and the only Society for investigators, biomedical research scientists involved in the study of blood diseases.

I would like to point out over the next few minutes four representative diseases of the blood that we have made major progress over the last couple of years, since you have my formal statement before you.

I would like to talk to you briefly about AIDS, leukemia, heart disease and cancer.

AIDS is the disease which is caused by a virus called the HTLV-III virus. We have made a tremendous contribution. We now know that the AIDS—we have isolated the AIDS virus, and we now know how it affects cells, what cells it does infect, blood cells, and what it does to those cells in terms of making the body's defenses against infection severely compromised.

Rarely in the annals of science has so much been contributed in so short a period of time as to the understanding of this disease. We have made tremendous progress in the control of the spread of this infection, because this disease would spread like wildfire through the population if we hadn't developed technology to detect the virus in blood, so that you, Congressman, for example, and your colleagues, your family can have blood transfusions now without the threat of becoming infected with the AIDS virus.

The AIDS virus, HTLV-III, is strongly related to the virus HTLV-I. HTLV stands for Human T-Cell Leukemia Virus, which is the first virus to be shown to cause a cancer in man, a truly amazing discovery that has come about over the last couple of years.

Viral cause of cancer, and we know how this virus affects cells, and clinical trials are underway to prevent this virus from infecting cells.

And therefore, to develop an approach to leukemia, a new leukemia.

Heart disease and stroke, we now learned that when the blood cells release a growth factor which causes the proliferation of blood vessel elements, that leads to heart disease and stroke, this will give us a new avenue of approach to the control of heart disease and stroke, a major contribution.

Similarly, this understanding of blood factors released from cells, growth factors released from cells, has made a tremendous contribution to our understanding of cancer and malignancy, because these growth factors cause the proliferation and the uncontrolled growth of normal cells, turning them into malignant cells, and we now know this is under the control of genes called oncogenes, and the control of the expression of oncogenes, what turns them on and off, is a very new approach to the understanding at the molecular level of what causes cancer, and how to control it.

And surely in the future years, upcoming years, major breakthroughs are going to occur on the basis of these new scientific discoveries, so we have tremendous progress in AIDS, leukemia, heart disease and stroke, and in cancer, and we need to continue that work unabated in the near future, so we need 6,000 RO-1s, and that $6,100,000,000 budget in fiscal year 1987, and we appeal to you for your support.

Mr. NATCHER. Doctor, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Schreiber follows:]

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1986

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TESTIMONY

OF THE

AMERICAN SOCIETY OF HEMATOLOGY

Presented by

Alan D. Schreiber, M.D.

Member

Public Education Committee

American Society of Hematology

and

Professor

University of Pennsylvania

School of Medicine

MAY 7, 1986

28th Annual Meeting: December 6-9, 1986—Moscone Center, San Francisco, CA
Business Office: SLACK Incorporated, 6900 Grove Road, Thorofare, NJ 08086 (609) 848-1000

Mr. Chairman and members of the committee:

On behalf of the American Society of Hematology and its more that 3,000 members, I thank you for the opportunity to present testimony before the Subcommittee again this year in connection with the legislation for the fiscal 1987 appropriations for the National Institutes of Health.

I am here today representing the Public Education Committee of the American Society of Hematology. This Society is the only national organization of hematologists and is made up of physicians and biomedical scientists who are concerned with research, patient care and teaching as they relate to blood.

Before presenting our views about this legislation, I would like to express my deep gratitude to the members of this Committee and to the entire Congress for their very strong support last year on behalf of biomedical research and hematology. We greatly appreciate your long-standing commitment to the programs of the National Institutes of Health. We are particularly pleased with the strong support given by the Congress to investigator-oriented research. The creative imagination of our nation's scientists represents one of our country's greatest natural resources. The support that you have directed to these scientists provides the raw materials upon which their ideas will flourish.

The fluid and cellular constituents of blood are critical in maintaining many of life's processes. Flowing as they do through every organ of our body, abnormalities of the blood affect many organ systems. It is natural, therefore, that blood research is supported by a number of institutes, particularly the Heart, Lung and Blood Institute, the Cancer Institute, and the National Institute of Diabetes, Digestive and Kidney Diseases. This spectrum of support has been most productive for hematology research and for the broad research mandates of the individual institutes, and we feel strongly that each of these institutes should continue to direct funds for the support of blood research.

AIDS is a good example of a disease transmitted in blood that affects one of the important blood cells, the lymphocyte. Its manifestations are seen in the dysfunction of many organ systems. Hematologists have been among the scientists leading the way in identifying the AIDS agent, defining the biologic processes through which it acts, and now working to identify means of controlling this process. Support for hematologists conducting AIDS research has been provided by each of the three institutes just named. The great progress in the understanding of AIDS made thus far is a credit to the organization of the NIH itself and to the strong partnership which exists between the NIH and the many scientists making up the biomedical research community. The system works. Recent Congressional action has directed that funds for AIDS research, including funds within the NIH, be redirected to the Office of the Assistant Secretary for Health. We believe that the proper place for AIDS research funds is within the NIH and not within the Office of the Assistant Secretary. We urge the Congress to redirect research funds properly the province of the

NIH back to the NIH. While we respect the need for coordinating various aspects of AIDS research, including fundamental biology, epidemiology and therapy, we wish to emphasize that progress in this disease has occurred at a rate unparalleled in the history of human discovery, and that progress has been made under the effective and enlightened guidance of the NIH. We urge the Congress to ensure that the research success of the past will continue in the future under the aegis of the National Institutes of Health.

In order for the NIH to be effective and to be responsive to the biomedical research community it must have flexibility. We are concerned that the distribution of funds within institutes as required by the Office of Management and Budget impairs that flexibility. If the NIH in general, and the individual institutes in particular, are to be responsive to the shifting needs in biomedical research, needs which the NIH leadership understand very clearly, that leadership must have the flexibility to move funds as they and their advisory groups deem best.

Over the past year enormous progress has been made in many areas of hematology research. We have learned a great deal about the adhesive qualities of blood platelets, cellular elements which are so important in controlling bleeding. We also know that the adhesive qualities lead to excessive blood coagulation, which results in strokes and in heart attacks. We hope that this new knowledge of the adhesive qualities of platelets will lead to therapies which will control these devastating diseases.

Work on the synthesis of hemoglobin, the molecule within red blood cells responsible for carrying oxygen, has led to a new plateau of understanding about the genetic control of protein synthesis. Work on the hemoglobin genes over the past decade forms much of the foundation for our current level of research in molecular biology. Efforts of hematologists are targeted on a number of important diseases, particularly sickle cell anemia and Cooley's anemia.

Exciting discoveries concerning specific genetic abnormalities in the human leukemias have helped in defining a set of genes which we know now to be critically important in normal growth control and which, when functioning abnormally, fuel the malignant process. These genes have come to be known as "oncogenes". Many share with me a confidence that, with our understanding of the genetic abnormalities responsible for malignant disease will come new strategies for conquering cancer.

Aplastic anemia, a progressive and usually fatal disease typically resulting from an unexplained failure of the bone marrow to produce blood cells, is now frequently treated successfully with drugs that affect the immune system. In other patients, bone marrow transplantation offers the hope for long-term cure. We have seen the technology of bone marrow transplantation extended to the therapy of patients with acute leukemia. This technology, which heretofore has relied on bone marrow donated by siblings of the affected individual, has now been expanded to the use of unrelated compatible donors found in large computer searches of individuals who have been typed by some of our leading blood transfusion centers. This expanded pool of potential bone marrow donors opens new horizons for individuals who do not have suitable family members who might serve as donors of normal bone marrow. This new approach is not without many pitfalls, but we believe that research now ongoing will overcome many of these pitfalls and extend the technology of bone marrow transplantation even further.

These are only some of the important advances in hematology research. The biomedical research community has climbed to enormous heights of new knowledge. The explosion of biomedical technology it has created continues to catapult this process. Increasingly difficult questions are being approached, and increasingly difficult answers are being found. This is a costly process. It is costly in dollars, and it is costly in personal commitment. The new knowledge acquired not only forms the basis for future biomedical discovery, it provides the foundation for new biomedical research industries which are creating jobs for many of our citizens and breathing new life into many of our heretofore aging cities. Our nation's investment in biomedical research has become not only an investment in the future health of our loved ones, it has become an investment in the health of our economy. The investment has been in basic, investigator-initiated, non-directed, creative research. It is to this research that the energies of the NIH must be directed. The current success of this research and its promise of future successes are strong imperatives for support of NIH research at a level of no less than $6.1 billion for fiscal 1987.

The American Society of Hematology makes the following recommendations, and expresses concerns as follows:

1. That appropriations for FY 1987 for the National Heart, Lung and Blood Institute, and the National Institute of Diabetes and Digestive and Kidney Diseases be funded at a level of at least "maintenance of effort" levels, based upon the pre-sequestration FY 1986 appropriated funds, with sufficient increase to account for inflation.

   Suggested levels:

   NHLBI: $950.3 million

   NIDDK: $504 million

2. That blood transfusion centers, called for in the appropriations bill report language last year, be funded in FY 1987 at the peer review recommended level (particularly important because of the AIDS public health threat).

3. That AIDS funding be an add-on, and not taken from on-going programs (in FY 1986, in order to fund AIDS research, the percentage of blood research funding decreased from 17% of the NHLBI budget to about 15%), in FY 1987.

4. That Congress carefully consider the impact of the proposed movement of funds from the Institute level for AIDS research to the office of the Assistant Secretary for Health. It is at the Institute level, and the NIH level, that scientific understanding of opportunities is best understood and followed. There is no need for a "czar" over AIDS research; there is concern that insufficient scientific experience would be present in ASOH; and there is concern that decisions at that level would be open to potential political, rather than scientific, influence on decisions.

5. That the appropriations process, which can affect program decisionmaking at the institute level, be informed that this Society supports the continuation of the excellent hematology research program at the NIDDK as it is presently constituted.

   Last year's biomedical research authorization law carried language requesting the Director of NIH to study the structure of the NIDDK to determine whether some programs would be better administered if shifted to other institutes. This Society has studied the matter and expresses its belief that hematology research programs in the NHLBI and NIDDK are both excellent, and mutually supportive, and coordinated in such a fashion that there is not overlap of research. We have expressed this opinion to NIH.

6. That the Institutes of the NIH be permitted to retain the flexibility they require in terms of movement of funds between mechanisms of support as scientific opportunities present themselves. We oppose strongly OMB's attempts to limit this flexibility.

Thank you.

American Society of Hematology

1986

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FACT SHEET

FOR APPROPRIATIONS TESTIMONY, 1986

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WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESS

DR. CRAIG C. KESSLER, MEMBER, BOARD OF DIRECTORS, THE NATIONAL HEMOPHILIA FOUNDATION

Mr. **NATCHER**. Our next witness is Dr. Craig Kessler. Come around, Doctor.

Doctor, we are glad to have you before the committee, and we will be pleased to hear from you.

Dr. **KESSLER**. Thank you, Mr. Chairman.

Mr. Chairman, and subcommittee members, I am Dr. Craig Kessler, and I am speaking to you today as a representative of the National Hemophilia Foundation, and I also direct the adult component of the Washington, D.C. Area Comprehensive Hemophilia Care Center at the George Washington University Medical Center, which is one of the regional programs being funded by the Federal Government.

This year is the 10th anniversary for Federal support for comprehensive hemophilia care, and we are grateful for the support you have provided during this period.

Since 1976, Federal funding has supported the development of 24 comprehensive treatment centers into a strong regional network under the Division of Maternal and Child Health. The centers care for nearly 50 percent of the total hemophilia population and their impact has been dramatic.

Since 1976:

One, the number of patients seen at treatment centers has increased more than 343 percent.

Two, the number of patients receiving comprehensive care and the number on home care therapy has increased nearly five-fold.

Three, the numbers of hospital days per year per patient has been reduced by 80 percent.

Four, there has been a 73-percent reduction in the number of days lost from work or school each year.

Five, the percent of unemployed adults has dropped from 36 percent to 9.4 percent.

And six, the average cost of health care per year has been reduced from $31,600 to $8,127. This 74-percent reduction in total health care per patient represents an annual national savings of $223,000,000. This is a handsome return on the Federal Government's $3,600,000 investment.

In 1981, hemophilia treatment centers funding was included in the 15 percent set aside for MCH fundings amounting to 3,300,000. In 1985, the funding was increased to 3,600,000, only 9 percent higher than five years previously.

This increase helped to stabilize established services, but in no way addresses our real needs.

The network of hemophilia treatment centers currently do not reach 25 States. In addition, current allocations are not adequate to support expansion of established psychosocial and medical services.

Your committee has heard much about AIDS over the past four years. Since 1982, there have been 172 cases of AIDS reported among children and adults with hemophilia. 99 have died.

One of every 115 hemophiliacs has contracted AIDS, and for those with severe hemophilia, the incidence is 1 in 65.

90 percent of severe hemophiliacs have been exposed to the HTLV-III virus.

Two wives of hemophiliacs have contracted AIDS.

It is estimated that 1 to 5 percent of sexual partners of hemophiliacs will convert to HTLV-III positivity each year unless preventive measures are instituted.

And one child of a hemophiliac has contracted AIDS.

It is ironic that the same blood products which have freed hemophiliacs from much disability and physical pain have now contributed to their death and social stigmatization.

Our centers, particularly with respect to the psychosocial care they provide, have served as anchor of support and have abated the sense of panic, fear and hysteria.

The extensive collaboration between the public and private sectors has substantially reduced the risk of AIDS among hemophiliacs by testing blood donations for HTLV-III contaminations, however, special attention is required to address the AIDS-related stress experienced by families and patients. How many of the 90 percent of the hemophiliacs who are HTLV-III-positive will succumb to AIDS?

These issues that I have addressed can be translated into the following requests for appropriations:

We urge you to appropriate $4,900,000 for fiscal year 1987 to support the hemophilia treatment program. This represents a 1,300,000 increase over current funding, but it is essential for us to begin to address the needs of 50 percent of hemophiliacs whose care is currently not within the regional comprehensive programs established by the Division of Maternal and Child Health.

We request retention of the 15 percent set aside within DMCH appropriations. This arrangement has proved to be efficient and has been adapted for other chronic diseases and necessitates that MCH funding be maintained at the full authorization level.

With rising public concern about the heterosexual transmission of AIDS and HTLV-III infection, development of risk reduction strategies are important among hemophiliacs. Furthermore, the hemophilia community represents a model for heterosexual transmission.

The health education and behavioral change experiences of the hemophilia community, mediated by HTC, will eventually benefit the general public during the AIDS epidemic.

To assist us to address risk reduction, psychosocial, education and training needs, we request a $4,300,000 special appropriation to the CDC, which would distribute these funds in fiscal year 1987 through the existing regionalized hemophilia treatment centers.

Our goals to eradicate AIDS and to provide hemophiliacs with clotting factor products free of contaminating virus require much research and development. We, therefore, are vitally concerned that adequate funding for basic biomedical research be provided to the NIH, especially through the blood diseases and AIDS research programs.

Additionally, we feel that the CDC needs increased funding to expand their excellent laboratory investigations and epidemiologic studies.

Over the last 10 years, your generous support has generated remarkable improvements in hemophilia research and treatment. Today we are facing very serious and difficult problems due to AIDS. Therefore, we are asking you to help us find more support for comprehensive care, research and AIDS risk reduction with the potential to provide benefits to the hemophiliac community and to society at large.

Thank you.

I would be happy to answer any questions.

Mr. NATCHER. Thank you very much, Dr. Kessler. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Kessler follows:]

THE NATIONAL
HEMOPHILIA FOUNDATION

TESTIMONY SUBMITTED TO

HOUSE SUBCOMMITTEE ON LABOR, HHS APPROPRIATIONS

HEMOPHILIA TREATMENT
AND
RESEARCH

STATEMENT BY: THE NATIONAL HEMOPHILIA FOUNDATION

By: Craig M. Kessler M.D.

Associate Professor of Medicine

George Washington University Medical School

Washington, DC

May 7, 1986

THE SOHO BLDG. • 110 GREENE ST. • RM. 406 • NEW YORK, NY 10012 • (212) 219-8180

I am Craig M. Kessler, MD. I am Associate Professor of Medicine at George Washington University Medical School, and I am speaking to you today as a representative of The National Hemophilia Foundation (NHF). In addition to serving on NHF's Board, I chair the Medical Advisory Board of the Washington, DC Area Chapter of NHF. I am also the Director of the adult component of the Washington, DC Area Comprehensive Hemophilia Care Center of George Washington University Medical Center, one of the regional programs funded by the Federal government.

This is the 10-year anniversary of federal support for comprehensive hemophilia treatment centers (HTC). I am proud to say, that the Washington, DC Area Chapter will be hosting The Foundation's 38th annual meeting in September, at which time we will celebrate this anniversary. NHF is grateful for the support that you have provided over the past decade for this program, and which as you are aware, has hastened a revolution in hemophilia treatment. Federal support of comprehensive care, coupled with availability of plasma clotting factor concentrates, has made home infusion therapy possible, freeing patients from a life of hospital care and emergency room visits. There is no better example of the rapid translation of scientific advances into patient care.

COMPREHENSIVE CENTERS - In 1976, the first year of Congressional support for the Comprehensive Hemophilia Diagnosis and Treatment Center Program, federal funding was provided to support the development of 24 comprehensive HTCs and 60 affiliates. Under the leadership of Dr. Merle McPherson of the Division of Maternal and Child Health (DMCH), the network of centers has expanded and now includes a strong regional structure. Over 9,500 hemophiliacs (nearly 50% of the total hemophilia population) are now served by these centers, which provide multidisciplinary services including psychosocial, financial and vocational counselling, in addition to medical, dental and orthopedic care. The impact of these programs has been dramatic. Between 1975 and 1985:

- the number of patients seen at primary treatment and/or affiliate center sites increased more than 343%;
- the number of patients in these regions receiving comprehensive care and the number on home care has increased nearly fivefold;
- the average number of hospital days per year per patient has been reduced by 80%; from 9.4 to 1.6;

- there has been a 73% reduction in the number of days lost from work or school each year;
- the percent of unemployed adults dropped from 36% to 9.4%; and
- the average costs of health care per year has been reduced from $31,600 to $8,127. (adjusted for inflation, in 1985 dollars).

These important human benefits have been accomplished through a program that has also led to significant economic savings. Careful studies have documented a 74% reduction in total health costs per patient in 1985, as compared with 1975. This $23,473 per patient savings represents an annual national savings of $223 million -- a handsome return on the federal government's $3.6 million investment. There is no mystery as to how these savings are achieved - comprehensive care prevents complications that require costly hospitalizations. In addition, comprehensive care prepares patients for home therapy so that they do not need 25-50 hospital visits each year for bleeding episodes.

Thus: Congress' investment in comprehensive care programs which promote home infusion therapy has paid off by reducing disability, unemployment and the cost of medical care for patients with hemophilia.

THE FUTURE OF HEMOPHILIA TREATMENT CENTERS - In 1981, HTC funding was included in the 15% set-aside for MCH funding. At that time, federal support of HTCs was $3.3 million. Last year, thanks to your support, the funding was increased to $3.6 million. The total funds available to centers in 1986 will be an increase of only 9% over the amount received five years ago. This increase helped to stabilize established services, but there are still 25 states that are not entirely covered by the regional federal treatment center network.

Two years ago, an *ad hoc* Aovisory Panel to the DMCH Hemophilia Centers Program issued a series of recommendations concerning future directions of this program. The panel's report documented the need for increasing funding support for maintaining these centers, expanding psychosocial services, improving coverage to underserved areas through regionalization, improving third party reimbursement for the treatment of hemophilia, as well as identifying 11 areas requiring targeted special efforts. The need for and merits of comprehensive care were documented the need for increasing funding support for maintaining these centers, expanding psychosocial services, improving coverage to underserved areas through regionalization, improving third party reimbursement for the treatment of hemophilia, as well as identifying 11 areas requiring targeted special efforts. The need for and merits of comprehensive care were also cited in a 1985 report of the Office of Technology Assessment (See attached OTA citation).

AIDS: A SERIOUS PROBLEM THAT MAKES THE COMPREHENSIVE TREATMENT CENTERS EVEN MORE ESSENTIAL - Your Committee has heard much testimony about AIDS over the past four years. Of special concern is that, since July of 1982, there have been 172 cases of AIDS reported among children and adults with hemophilia, and 99 have died. The recognition that AIDS is transmitted through blood products has had a profound effect on families affected by hemophilia across our entire country. It is a stinging irony that these blood products, which have provided people with hemophilia with a newly found freedom from pain and disability, have been identified as the source of their vulnerability to AIDS. This crisis has created a need for comprehensive care that is greater than ever before. These centers, particularly with respect to the psychosocial care being provided, have served as anchors of support during this critical period - without them, there surely would have been widespread panic. But now, the need for risk reduction and psychosocial services is increasing more than ever before and will continue to do so in the immediate future because of the profound impact of data that has recently surfaced:

- one in every 115 individuals with hemophilia has contracted AIDS and, for those with severe hemophilia, the rate is one in 65 (when I testified before this committee last year, the rate was one in every 270);
- it is now known that 90% of persons with hemophilia have been exposed to the HTLV-III virus;
- two wives of men with hemophilia have contracted AIDS;
- it is estimated that, unless preventive measures are utilized, 1 to 5% of sexual partners of people with hemophilia will convert to HTLV-III positive status each year;
- one child of a man with hemophilia has contracted AIDS; and
- an increased number of AIDS cases have been reported in patients with mild and moderate hemophilia.

infection and hemophilia. These objectives are now being addressed by the treatment centers you created 10 years ago.

PROGRESS IN REDUCING THE RISK OF AIDS AMONG PEOPLE WITH HEMOPHILIA - As a result of enormous collaborative efforts between the public and private sectors, there has been substantial progress in reducing the risk of AIDS among patients and families affected by hemophilia. Blood donations are tested and blood products used by people with hemophilia are heat treated. Based on these advances, blood products used for treatment of hemophilia are virtually free of HTLV-III contamination.

Concern remains, however, about the large percentage of people with hemophilia who are antibody positive and the potential for the transmission of AIDS and/or HTLV-III infection to their sexual partners. Concern exists regarding the importance of people with hemophilia maintaining their treatment of bleeding episodes when medically indicated, despite their fear of AIDS. Special attention is also needed to address AIDS-related stress that is experienced by patients and families. But, most important of all, how many of the 90% of the people with severe hemophilia who are HTLV-III positive will succumb to AIDS?

APPROPRIATIONS REQUEST - The issues that I have addressed can be translated into the following requests for appropriations:

1. FY87 Appropriations for Treatment Centers - We urge you to appropriate $4.9 million for FY87 to support the HTC Program. While this is a $1.3 million increase over the current funding level, it is essential if we are to adequately address the needs of 50% of the patients not now within the regional comprehensive care programs established by DMCH. These funds would be used to expand the existing regional network to areas not currently served. To assure the continuation of these programs, we request that you retain the 15% level for a set-aside within the DMCH appropriations, because it is more efficient to distribute resources for certain disorders on a regional and national basis, rather than through block grants through states. The HTC Program is clearly a special program of regional and national significance and is a model for other chronic diseases. We also urge that MCH, of which the hemophilia program is a part, be

funded at the full authorization level, as this is an investment in our nation's future.

2. Emergency Appropriations for Risk Reduction, Education and Training - Now that the blood supply is no longer considered a source of HTLV-III transmission to the hemophilia community, the major concern is the potential risks associated with heterosexual transmission of AIDS and HTLV-III infection. The development of risk reduction strategies for the hemophilia population has added importance at this time, as there is increasing public concern about the heterosexual transmission of AIDS. The hemophilia community represents a model for heterosexual transmission, as its population is amenable to surveillance and is relatively self-contained and stable, with the highly regionalized services that are concentrated in the federally supported HTCs. To effectively reduce the risk of heterosexual transmission of AIDS/HTLV-III infection, it is important that the health education and behavioral change experiences of the hemophilia community be well understood and documented. These efforts among people with hemophilia will be of benefit to the general public during the AIDS epidemic.

AIDS has also caused considerable fear and confusion among patients, health professionals and the general public. The potential of heterosexual and perinatal transmission has had a profound social and psychosocial effect upon individuals and entire families. In some instances, due to the fear of AIDS, some patients have withheld treatment when medically indicated. What a tragedy it would be if the fear of AIDS were to catapult us back two decades, to the era of substantially increased bleeding causing deaths and severe joint damage. And, because most people with hemophilia are HTLV-III positive, it is of great importance that accurate information is provided so that there is not undue alarm in work, school and social settings. To assist us to address these risk reduction, psychosocial, education, and training needs, we are requesting the special appropriations in the amount of $4.3 million to the Centers for Disease Control. It is anticipated that CDC would distribute the majority of funds through the existing network of regionalized HTCs. Within the next several weeks, we will be bringing further information to you to seek your guidance as to how support for these urgent needs can best be accomplished in FY87.

3. Research - The success of comprehensive care and home infusion therapy might suggest that the "hemophilia problem" has been solved. Nothing could be further from the truth. Hemophilia is still an extremely painful and disabling disease. Clotting factor can effectively control bleeding but it is not a cure. And the AIDS tragedy has re-emphasized that, as long as people with hemophilia depend upon a factor derived from human blood plasma, they will be vulnerable to anything that may contaminate blood products. In addition, clotting factor inhibitors develop in over 10% of hemophilic patients and these antibodies seriously compromise subsequent care. For these reasons, we are vitally concerned that there be adequate funding for basic biomedical research supported by the NIH, and especially the blood diseases and resources research program of NHLBI and the important research conducted by NIADDK and NIAMSD. We are also grateful for Congressional support for increased AIDS-related research. Continued and increased funding is needed in this area. The NIH, including NCI, NIAID, and NHLBI must receive sufficient funding to support a multifaceted research effort that will lead to a better understanding, control, and widespread distribution of experimental drugs through the regionalized network of HTCs when promising results occur in phase I and phase II trials now being conducted at NIH. Additionally, the Centers for Disease Control need increased funding so that they can expand their excellent laboratory investigations and epidemiologic studies and the FDA needs support to expand their surveillance of the safety of blood products.

SUMMARY - Over the last ten years we have been most pleased with the support you have provided for hemophilia research and treatment. The results of your investment have been remarkable. But today, we are faced with very serious and difficult problems as a result of AIDS. Therefore, we are asking you to help us find more support for comprehensive care, research and addressing the unique problems faced by the hemophilia community as a result of AIDS.

Thank you.

OFFICE OF TECHNOLOGY ASSESSMENT

Blood Policy and Technology (Washington, DC: U.S. Congress, Office of Technology Assessment, OTA-H-260, January 1985

OTA on Medicare and Hemophilia:
"Opportunities exist for improving health care provisions for hemophiliacs, if not by creating a special program for them, then by providing coverage for blood products on an outpatient basis." (The OTA Report recommended expanded coverage for hemophiliacs, pointing out the inadequacies of Medicare which determines eligibility on a case-by-case basis; instead of by universal entitlement.)

OTA on Comprehensive Care and Hemophilia:
"The situatiion for hemophiliacs has improved dramatically since passage of Public Law 94-63 in 1975." (Federal support of regional comprehensive hemophilia treatment centers.)

OTA on Cost Savings and Hemophilia:
"Compared to the year before the programs had started, the cost of total care, including rates of hospitalization, has been reduced, and unemployment among hemophiliacs is lower."

OTA on Other Economic Benefits and Hemophilia:
"The proportion of patients with third-party coverage has also grown, both because employment of hemophiliacs increased as a result of better treatment, and because health care workers at the centers have helped patients arrange for coverage."

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESSES

VIVIAN GIORDANO, COOLEY'S ANEMIA FOUNDATION

RALPH CAZZETTA, MEMBER, THALASSEMIA ACTION GROUP

Mr. NATCHER. Our next two witnesses are Vivian Giordano and Ralph Cazzetta. Come around. We are glad to have both of you before the committee at this time, and we will be pleased to hear from you.

Ms. GIORDANO. Thank you for allowing us to testify regarding the appropriations for research of thalassemia, or Cooley's anemia. Ralph and myself are patients of Cooley's anemia, and President and Vice President of a newly formed group called TAG.

We want to thank you very much for helping us and your support. Because of you and your help, Ralph and I are allowed to live a longer and more normal life. Cooley's anemia is a fatal blood disorder through genetics, heredity, and most commonly found in Italians and Greek descent.

We have found recently that there are other nations in the world that have patients who are diagnosed as Cooley's anemia patients. Through your support, there has been research that has found desferal, and iron kelator.

We have an overabundance of iron which is deposited in the organs, and suffocates them and therefore, many of our patients die of heart, kidney or, worse, liver failure, and I wanted to tell you that, and I would like Ralph to give you our testimony.

Mr. NATCHER. Vivian, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Ms. Giordano follows:]

COOLEY'S ANEMIA FOUNDATION, INC.
SUITE 911 • 105 EAST 22nd STREET, NEW YORK, NEW YORK 10010 • (212) 598-0911

TESTIMONY

OF THE

COOLEY'S ANEMIA FOUNDATION

Concerning the FY 1987 Budget for Certain of the
National Institutes of Health and the
Maternal and Child Health Administration Programs

Before the

HOUSE SUBCOMMITTEE ON LABOR-HHS-EDUCATION APPROPRIATIONS

MAY 7, 1986

1110 Vermont Avenue Northwest Suite 820 Washington, D.C. 20005 202 822 9380

American Heart Association
Office of
Public Affairs

American Heart Association

Statement on

FY 1987 Appropriations for the

National Institute of Neurological and Communicative
Disorders and Stroke (NINCDS)

and the

Division of Research Resources (DRR)

Submitted to the

House Labor-HHS-Education Appropriations
Subcommittee

The Honorable William Natcher, Chairman

May 12, 1986

Summary of Recommendations:

NINCDS -- $479.3 million
DRR -- $370.5 million

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WE'RE FIGHTING FOR
YOUR LIFE

Mr. Chairman, thank you for permitting us to testify regarding appropriations for research and care in Cooley's Anemia. I am Vivian Giordano, and with me is Ralph Cazzetta; both of us are members of the Thalassemia Action Group, a network of thalassemia patients 13 years old and over who felt the need to join together. I am also a member of the Legislative Committee of the Board of Directors of the Cooley's Anemia Foundation.

Allow me to give you some background about the Cooley's Anemia Foundation. The Foundation was founded over 27 years ago by a group of volunteers whose families had been stricken by Cooley's Anemia, named after Dr. Denton Cooley who discovered the disease, a fatal genetic blood disorder.

Thus, on September 20, 1954, the original core of volunteers officially incorporated the Cooley's Anemia Foundation in the State of New York as a national voluntary health agency for the express purpose of coordinating national and regional research activities, educating and counseling the public at risk (an estimated 20 million carriers of the genetic disease exist in the United States), providing patient care and family support services for those stricken with the disease, and also establishing professional education programs to provide the medical profession with forums in which to objectively share information about the disease and its treatment.

Cooley's Anemia, as indicated above, is a fatal blood disease that is passed from parent to child. It normally strikes children of Mediterranean-American parents including those of Italian and Greek descent, as well as Syrian, Israeli, and other population groups, including those from Asia.

For your information, we have attached to this testimony a brochure which was requested specifically by this Committee several years ago from the Department of Health and Human Services, which has been used widely throughout the United States, largely disseminated through out chapter network, to inform people not only about the disease, but about carriers of the disease. As you can see, the brochure stresses prevention through understanding.

We are extremely grateful to this Committee for the large amount of support that you have given to us over the past nine years that we have testified before your Committee.

We would like to express at this time several serious concerns that we have, which inpinge directly upon Cooley's Anemia patients and carriers.

First, we urge you to develop bill report language or some other mechanism by which the Maternal and Child Health Administration would be urged to continue those programs now existing in New England and in New York for the research and care of Cooley's Anemia patients. This program was established four years ago, has been on-going, and has been very successful. The Maternal and Child Health Administration of the Health and Human Services Department has been very supportive of this program, which is funded under the 15% set-aside for programs of national and regional significance.

Second, we wish to express our deep concern about the cuts that have been proposed by the Administration for fiscal year 1987, especially as to research. Specifically, we are concerned with the proposed cuts for the National Institutes of Health, which would cause the budget for the NIH to fall substantially below that for fiscal years 1985 and 1986.

We would like to refer to two institutes in this regard, the National Heart, Lung and Blood Institute and the National Institute of Diabetes and Digestive and Kidney Diseases.

In regard to the National Heart, Lung and Blood Institute, we wish to express our concern that many of the programs in hematology, which bear directly on Cooley's Anemia, will be suffering if the Administration's proposed fiscal year 1987 levels are agreed to. For example, we are very concerned about the intramural research program, which has been extremely successful in developing work on animal models (the rhesus monkey) for trials of bone marrow transplants and the use of drugs in that regard. There has been some indication that the rapid forward movement in this field might be curtailed by the lack of funding for this intramural research project. We believe that for the Cooley's Anemia patients this is an absolutely vital issue.

We were also very concerned with the statements made by NIH witnesses when they appeared before this Committee about the transfer of research money into the AIDS research program. As you may know, Mr. Chairman, over $11 million has been committed to the AIDS research program in fiscal year 1986 from NHLBI. All of those monies have been taken away from other activities, including research on Cooley's Anemia and other blood programs. We know of the importance of AIDS, and in fact are very concerned ourselves as all Cooley's Anemia patients need continuous blood transfusions. But we believe that money for AIDS research should be a "add on" on top of all other programs and not taken away from necessary blood programs that are now going forward.

Third, in regard to the National Institute of Diabetes and Digestive and Kidney Diseases, we want to express the same concerns. Now that the sequestration program has been effected under Gramm-Rudman-Hollings for fiscal year 1986, we find that the losses there will severely restrict basic research programs in the hematology area at this institute. This institute has been extremely supportive of Cooley's Anemia research, and we would like to see funds restored to that institute so that it may continue forward on its basic research.

And, Mr. Chairman, while we are on the subject of the NIDDK, let us say that we fully and strongly support the concept that the hematology program in the institute be continued there. It has an important role in terms of basic research in that institute. We hope that that program will remain in that institute, and we know that it works very well with the blood programs in the National Heart, Lung and Blood Institute. We are aware that last year when the biomedical research authorization bill was agreed to by the Congress that one of the requirements in the legislation called for a study by the Director of the NIH as to whether all programs now in the NIDDK should be continued there. We want you to know that we are fully supportive of keeping the hematology program alive and well in that institute.

Fourth, Mr. Chairman, we want to express our appreciation to you for the bill report language that you provided a year-and-a-half ago which developed the first comprehensive Directory of State and Local Programs as well as Federal Programs which can assist Cooley's Anemia patients. A copy is appended to this testimony, not for the record but for your information. This Directory has been widely disseminated throughout the patient community.

Lastly, Mr. Chairman, we support the Ad Hoc Group for Biomedical Research Funding's request for the overall NIH funding of $6.07 billion.

Mr. Chairman and Members of the Committee, you have always been very supportive of Cooley's Anemia resaerch and care programs, and we are deeply grateful.

We would be pleased to answer any questions you may have.

Mr. CAZZETTA. The Cooley's Anemia Foundation has the following suggestions for appropriations for research and patient care in regard to Cooley's anemia.

One, that the Cooley's anemia research, treatment and care programs now underway in New England and New York, under the 15-percent set-aside of the Maternal and Child Health Program "for programs of regional and national significance" be continued through fiscal year 1987.

Bill report language has appeared in the appropriations bills in the House and Senate in the last several years, and that has maintained the program.

Two, that considerable study be made of the impact of removing funding from the NHLBI and NIDDK for AIDS research.

We recognize the serious nature of this public health problem, but note that Cooley's anemia patients are also at risk, subject as they are to continuous transfusions.

We also believe, however, that the AIDS funding has been taken from ongoing blood disease research programs, and has weakened them, and prevented new initiatives, particularly in the area of blood transfusion, and the development of drugs to deal with Cooley's anemia and other anemias.

Additionally, it is becoming clear that the enormously important work being done in the NHLBI and NIDDK intramural programs on bone marrow transplants and drug development is threatened. We understand that there is the potential that an intramural laboratory in the NHLBI which has chiefly been responsible for the work in Cooley's anemia research is now being threatened with fund withdrawal, and perhaps even defunding.

This would be a major blow to those of us concerned with Cooley's anemia.

Three, we support the Ad Hoc Coalition's request for funding levels of $6,070,000,000 for the NIH.

We further suggest that the so-called sequestration process, whereby deep cuts across the board in every program and sub-program, including the intramural research program, has already harmed research in Cooley's anemia and its associated basic biomedical research.

If additional cuts like those projected of an additional 10 percent or more for fiscal year 1987 do occur, we believe that some research teams which have taken years to develop will disintegrate, and our field of research will be set back years.

We therefore urge some system of action that will prevent Gramm-Rudman-Hollings cuts for fiscal year 1987.

Mr. NATCHER. Ralph, thank you very much. You have given us an excellent statement, and we want you and Vivian to know that we appreciate your appearance before our committee

Mr. CONTE. I want to join you in complimenting both Vivian and Ralph for their thoughtful and comprehensive statement. You have our support. I spoke to your group in New York City a few years ago. You are two beautiful people.

Mr. NATCHER. Thank you very much.

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESS

DR. THOMAS S. RYAN, PRESIDENT, AMERICAN HEART ASSOCIATION

Mr. NATCHER. Our next witness is Dr. Thomas Ryan.

Doctor, you have been before our committee before. We are glad to have you back, and we will be pleased to hear from you.

Dr. RYAN. I am Dr. Thomas Ryan, Professor of Medicine at the Boston University School of Medicine, and President of the American Heart Association, AHA.

The AHA is the only voluntary agency in the United States devoting all of its human and financial resources to one goal: The reduction of premature death and disability caused by heart attacks, stroke and other blood vessel diseases.

In accomplishing this goal, we work in partnership with several Federal research, education and prevention programs whose goals are similar in nature. Since 1948, the AHA and the National Heart, Lung and Blood Institute, NHLBI, have been active partners in the battle against cardiovascular disease, this Nation's leading cause of death.

I am pleased to appear before your subcommittee today to provide you with our comments and funding recommendations for the NHLBI.

Cardiovascular disease is responsible for almost 1,000,000 deaths each year. Heart disease, stroke and related disorders account for almost as many deaths as all other causes of death—cancer, accidents, et cetera—combined.

In 1986, the total economic costs associated with cardiovascular disease are estimated to be over $102,000,000,000 in direct medical expenses and lost output due to disability and death.

However, there is encouraging evidence that we are making progress against these diseases. Between 1964 and 1984, the death rate for all cardiovascular disease declined by 39 percent. The decline in the death rate for coronary heart disease was 40 percent and for stroke, 55 percent. These encouraging downward trends contributed to 76 percent of the decline in overall mortality between 1964 and 1984 in the U.S.

Throughout our 37-year partnership the research, training, education and community service programs of both the AHA and the NHLBI have had a significant impact on diseases of the heart and circulatory system.

While AHA continues to dedicate an increasing amount of its budgetary resources to cardiovascular research, we are hopeful that the NHLBI will be able to continue to take advantage of current and future research opportunities in the cardiovascular field.

We are becoming increasingly concerned that decisions made by Federal officials solely for fiscal reasons in the present may have a detrimental long-term impact on the ability of the Institute to make more critical decisions for appropriate scientific reasons.

Prior to commenting on the impact of the President's proposed fiscal year 1987 budget on the programs of the NHLBI, we would like to comment on the impact of the 4.3-percent Gramm-Rudman sequestration order.

Although each of the Institute's program mechanisms received the same percentage reduction in their dollar amount, the impact upon each is very different. While the Institute will still fund 886 grants as planned under the fiscal year 1986 appropriated level of $859,200,000, non-competing research project grants will have to be negotiated downward 5.3 percent from their original committed levels; competing research project grants will have to be negotiated downward 9.9 percent from study section-approved grants.

The sequestration reduction will have a much more severe impact on other Institute program mechanisms. Research center grants awarded after December 1, 1985 will have to be reduced by 10 percent.

Research career awards and other research grants will also have to be reduced. The number of full-time training positions in fiscal year 1986 will have to be reduced by 85. And major changes in the Institute's research contracts program will be required. Some activities planned for fiscal year 1986 will not be initiated and some ongoing activities may have to be completely cancelled.

And finally, intramural research and the research management and support function will have to be reduced by 30 FTE work-years and operating costs will have to be cut by a minimum of 15 percent.

In addition to the Gramm-Rudman funding cuts, we are very concerned with additional reductions that appear on the horizon. Although we have made great progress in the fight against cardiovascular disease, we must not become complacent because of past accomplishments.

Currently, it is estimated that over 63,600,000 Americans have one or more forms of cardiovascular disease; high blood pressure afflicts an estimated 57,700,000 individuals; 4,700,000 have coronary artery disease; 2,100,000 suffer from rheumatic heart disease; and over 1,900,000 Americans have suffered a stroke.

Furthermore, there is growing evidence that the incidence of heart attack may no longer be on the decline.

In order to continue to have an impact on the downward trend in mortality due to cardiovascular diseases, the NHLBI has planned to undertake several exciting new activities in fiscal year 1987, including the following:

Continuation of a clinical trials to assess whether intravenous injections of a thrombolytic agent during the early hours of an evolving myocardial infarction is efficacious. This drug therapy will be used in combination with a procedure known as PTCA or balloon angioplasty.

A study of the mechanisms that underlie normal cardiac morphogenesis in order to increase understanding of the etiology and pathogenesis of congenital heart failures.

A clinical trial to assess behavioral and lifestyle interventions contributing to an individual's successful adjustment after coronary artery bypass graft, CABG, surgery, and to identify operative, clinical and other factors that may predict early and late graft narrowing and occlusion after surgery.

An investigation into the feasibility, acceptability, efficacy and safety of dietary intervention in children with elevated LDL cholesterol levels. Potential adverse psychological responses to diagnostic labeling and dietary intervention will also be evaluated.

A study to determine whether PTCA is a safe and effective therapy in patients with severe multi-vessel coronary artery disease. In addition to clinical centers, the program will also establish a Data Coordinating Center and a central Angiographic Care Laboratory.

These are but a few examples of NHLBI's planned program initiatives for fiscal year 1987. We are very concerned that these and others, particularly the planned clinical trials, will not be allowed to proceed due to a lack of necessary funds.

The President's fiscal year 1987 budget proposals would require deep reductions in the programs of the NHLBI at a time when research momentum should not be slowed.

The President's budget includes only $785,700,000, an overall reduction for NHLBI of 4.5 percent from the fiscal year 1986 adjusted appropriation level of $822,300,000.

In addition, the President has proposed a recision for the Institute that would reduce the amount of grants the Institute plans to award in fiscal year 1986 from 886 to 817, a decrease of 69 grants.

We urge Congress to reject this proposed recision. It is simply another attempt by the Administration to reduce the grants NIH can fund below Congressionally-mandated levels.

The programmatic impact of the President's proposed 1987 budget on NHLBI will be devastating. The Institute will be able to fund only 802 new and competing research project grants as compared with the 886 grants that it funded in 1986; and funding for non-competing research projects will have to be negotiated downward an average of 11.5 percent.

The Institute's research centers programs would have to be reduced significantly under by the President's proposed budget. In 1986, the Institute allocated $82,800,000 for its research centers program.

It is estimated that in order to continue this same level of activity in 1987, the Institute would need approximately $93,000,000. The President's budget, although it calls for the same number of centers to be funded, provides only $75,700,000 for this purpose.

The NHLBI currently is funding 60 research center programs. In fiscal year 1987, 24 of these centers are up for renewal. It will be most difficult for the NHLBI to renew all of these highly meritorious proposals with the amount of money that has been allocated to the centers program under the President's fiscal year 1987 budget.

Research center projects serve as a highly effective means of concentrating resources, facilities and research personnel on high priority research areas. Centers are unique in their ability to combine a basic science focus and a clinical research focus with results in rapid translation of important findings into clinical applications. We believe it is highly unwise to underfund such programs.

Under the President's budget the dollar level and number of research career awards will be held constant, 364 awards and $21,900,000. In addition, the number of full-time training positions will have to be reduced from 1,627 to 1,500, a decrease of 127 positions.

A 1985 report on "Personnel Needs and Training for Biomedical and Behavioral Research" by the National Academy of Sciences finds that "NRSA training grants and fellowships are integral parts of the overall biomedical research program in this country and play a key role in maintaining the vitality of the program."

The report predicts that within the next five years, the demand for trained researchers will greatly increase. Should this shortsighted approach of level funding of cardiovascular research training continue, we may not be able to meet future research manpower needs.

While the amount provided by the President's budget for research contracts, $51,900,000, is a slight increase over the fiscal year 1986 level, approximately $1,100,000, it is far below the level required to maintain current and projected contract activities for fiscal year 1987, approximately $75,000,000.

The primary reason for the needed increase in fiscal year 1987 is that the phase in which many of NHLBI's contracts will be is the more expensive recruitment phase rather than the initial phase as they were in fiscal year 1986.

Several research contract programs would have to be delayed or eliminated should they be funded at the level proposed by the President. When one takes into account the amount of time and resources that would be lost due to a cancellation of currently-funded contracts, it would amount to a significant waste of biomedical research dollars.

The President's budget completely eliminates NHLBI's funding for construction grants. For the first time in recent years, in fiscal year 1985, Congress provided funding to the Institute for the much-needed renovation of laboratory facilities. Many new techniques and procedures are available now, however, no facilities exist in which to perform them.

The Institute received many requests for funding for construction assistance that received high-priority scores during grant solicitations last year that have not yet been funded.

We believe that this funding, at a minimum, should continue at its fiscal year 1986 level of $3,200,000.

And finally, the intramural research program of the Institute will have to reduce operating costs by as much as 25 percent under the President's proposed budget.

In order to illustrate the true impact of these proposed budget reductions, we would like to highlight one important program area, cholesterol research and education, at NHLBI. For over 25 years, the AHA has advised physicians and the public about the merits of a low-fat, low-cholesterol diet as a means of reducing the risk of coronary heart disease.

We are very excited about NHLBI's new National Cholesterol Education Program which is modeled after its highly successful National Hypertension Education Program. The area of cholesterol research and education is a prime example of an area where AHA and the NHLBI can work in a cooperative manner to tackle an important public health problem.

However, several program activities in this area are threatened by budget reductions in fiscal years 1986 and 1987.

In the area of cholesterol research, over $4,000,000 in grants has been approved in fiscal year 1986 but will not be funded as a result of budget reductions. One important workshop on the treatment of severe hypercholesterolemia has been cancelled, and another on the impact of dietary cholesterol on plasma lippoproteins and atherogenisis is in jeopardy.

Also in jeopardy is the Institute's ability to assist the Centers for Disease Control in the implementation of the Cholesterol Standardization Program. This effort is crucial to taking steps to make clinical laboratories more consistent and accurate in the measurement of cholesterol levels and represents one of the early priority activities of the National Cholesterol Education Program.

With regard to planned cholesterol research activities in fiscal year 1987, proposed budget reductions will endanger several promising areas of investigation, including the use of non-human primates to obtain a better understanding of the relationship of cholesterol and atherosclerosis; a clinical trial to study the effect of postmenopausal estrogen use on coronary heart disease in women; research into the effects of dietary factors on lippoprotein structure and metabolism; and research into the relationship between the Omega-3 Fatty Acids and atherogenesis.

In addition, a number of planned cholesterol workshops may not be held due to a shortage of funds.

In the areas of cholesterol education, in fiscal year 1986 the Institute's cholesterol-related publications have been reduced significantly in number.

In addition, the Institute has had to reduce its exhibiting schedule and its ability to respond to requests for spokespersons to talk about the NCEP at various conferences and meetings because of a reduced travel budget.

A workshop to stimulate both intervention and research related to cardiovascular risk reduction at the work site may not be held as well.

In fiscal year 1987, the Institute will have to reduce in scope some major activities that are already underway such as the major support services contract for the NCEP and the contract to develop broadcast and print materials to carry the program's message to the public.

The AHA believes that the Institute's efforts in cholesterol and education research should not be sidetracked or slowed at this critical time. Any reduction in effort as a result of a lack of funding in fiscal years 1986 and 1987 is most unfortunate and would ultimately lead to increased health care costs for the nation.

AHA believes that the programs of the NHLBI have been highly successful in the battle against cardiovascular disease because of the valuable principle which guides the Institute—maintaining research program balance.

While the cornerstone of its program is basic research, the Institute's staff, Advisory Council and the scientific community over the years have also stressed the importance of other program mechanisms such as clinical trials, population studies, specialized centers of research, SCORs, national research and demonstration centers, research career and training awards and development contracts.

The balanced program approach has enhanced the NHLBI's reputation as a worldwide leader in cardiovascular research. This is so because of its rigorous peer review process. Congress must realize that these programs do not represent a "wish list," but only 30 percent of NHLBI's approved research grant applications are actually funded.

At this time we would like to highlight some of our concerns regarding the increasing involvement of the Office of Management and Budget in the program activities of the National Institutes of Health.

As we understand the situation, as of August 1985 the OMB instituted a new mechanism for apportioning funds to the National Institutes of Health which, in turn, required the Office of the Director of NIH to adjust its allotment procedure to the individual institutes.

Prior to August of 1985, OMB apportioned funds to the NIH by institute total and then the Director of NIH allotted funds to the individual institutes with only two categories earmarked—SBIR and consulting services.

Allocation among programs of the remaining, and largest, part of the institute's budgets was left to the individual institutes. Now the institutes received their allotments for the NIH director in 13 categories, each broken down by number of awards and dollar amount as determined by OMB.

We do not believe that the OMB staff has the scientific expertise and outlook to be making these kinds of decisions; these decisions should be made by the individual institutes and their advisory councils with input from the biomedical research community. And even though institute directors have reprogramming authority, it is our understanding that this authority has been discouraged under this new system.

The administration's new allocation and apportionment procedures are threatening the success of NHLBI's time-tested approach to research.

In addition, it is our concern that continual focus on the number of grants to be funded by the Institute may also jeopardize the success of other program mechanisms.

For example, in 1980, 58 percent of NHLBI's extramural research budget went towards research grants, 14 percent towards research centers, and 17 percent went towards clinical trials. In 1986, these same programs mechanisms received 70.4 percent, 11.7 percent and 7 percent respectively of NHLBI's extramural research budget. This is a very disturbing trend indeed.

The NHLBI is by nature of the disease categories under its research mandate, a "clinical institute." In order to maintain program balance that addresses basic research needs as well as the clinical aspects of heart, lung and blood disease, the Institute and its Advisory Council must be given the proper amount of flexibility to allocate resources where they are most needed and where they will bring about the best results.

Recently, both the AHA Board of Directors and the NHLBI Advisory Council passed resolutions expressing their concerns regarding the new role of the Office of Management and Budget in determining and proscribing line items in the budget of the National Institutes of Health and individual institutes.

The AHA believes that micromanagement by a nonscientific agency such as the OMB adversely preempts the traditional flexibility of the NHLBI, its Advisory Council and the scientific community from participating in the setting of priorities for biomedical research.

Another concern we would like to touch upon briefly is the steady decline of NHLBI's budget as a percentage of the entire NIH budget.

In 1976, the NHLBI received 16.5 percent of the funds allocated to NIH; in 1986, the Institute's share of NIH funds is only 14.4 percent. Diseases of the heart, lung and blood kill more Americans than all other diseases combined. We believe that the Institute's allocation of funds should reflect this very important fact.

The AHA believes that the President's budget request for the National Institutes of Health is highly inadequate. Adequate funding of research is not only an investment in this nation's future health but produces significant savings in health care costs as well. Generally it has been estimated that for each dollar spent in biomedical research, there is a return of from $10 to $16 in costs due to medical care.

Specific examples of advances in the cardiovascular field which have led to significant cost savings are advances in coronary artery surgery research and percutaneous transluminal coronary angioplasty which have resulted in annual net savings to the nation of over $654,000,000.

We endorse the Ad Hoc Group for Medical Research's funding recommendation for NIH of $6,100,000,000, a 10.6 percent increase over the fiscal year 1986 appropriations level. This level of increase is consistent with those proposed by the President for other Federal research and development activities.

For example, the President requested a 25 percent increase for the R&D activities of the Defense Department; and a 13 percent increase for the R&D activities of both the National Science Foundation and the National Aeronautics and Space Administration.

A 10.6 percent increase for NIH would allow for modest growth over its current services budget level and would allow for:

Competing and noncompeting research grants to be funded at full study section-recommended levels; some growth in research careers awards and sufficient funding to raise the current level of research trainees to that recommended by the National Academy of Sciences, 11,500 trainees; urgently needed upgrading and renovation of primate centers and outmoded and inefficient research laboratories; and a slight increase in the number of research centers.

We therefore recommend an increase of 10.6 percent, or a fiscal year 1987 appropriation of $950,300,000 for the National Heart Lung and Blood Institute. This level of funding has also been recommended by the NHLBI Advisory Council as the minimum amount needed for NHLBI to maintain its current research programs.

Just in conclusion, as President of the AHA for the last 18 months, I have been overwhelmed by the response of the citizens across the Nation who voluntarily contribute in excess of about

$150,000,000 to the AHA's primary mission, the support of biomedical research.

They do this, I am convinced, because of their conviction of the importance of cardiovascular research, and it is in this very area that we have our highest level of credibility with the public.

I am certain that it is in this area, cardiovascular research, that the Federal Government programs enjoy the highest level of credibility among the electorate.

It is certainly my honor to represent this large constituency before your committee. I think it is your privilege, and above all, your duty, to serve these expectations for the public at large, and the biomedical research community in particular.

Thank you very much.

Mr. NATCHER. Dr. Ryan, thank you very much. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of the American Heart Association concerning NINCDS & DRR follows:]

The American Heart Association is the only voluntary agen[illegible] the United States devoting all of its human and financial resources to one goal: the reduction of premature death and disability caused by heart attacks, stroke and other blood vessel diseases. In accomplishing this goal we work in partnership with several research, education and prevention programs whose goals are similar in nature. One of these programs is the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS). We are pleased to have the opportunity to provide you with our comments and funding recommendations for the NINCDS.

In addition, because of our concern regarding the use of animals in research and the President's proposed elimination of the Biomedical Research Support Grant (BRSG) program, we have included comments and recommendations with regard to the NIH's Division of Research Resources in this statement as well.

Cerebrovascular disease (stroke) is the third leading cause of death, behind heart attack and cancer, and the leading cause of long-term disability in the U.S. Approximately 500,000 individuals suffer a stroke each year; in 1983 over 156,400 individuals died of stroke. Survivors of stroke now number almost two million. These individuals often face years of severe physical and mental impairment, emotional distress and overwhelming medical expenses. It is for these reasons that stroke is generally viewed as the most devastating of all human disabilities. It is also one of the most costly as well -- each year stroke and its consequences cost the nation over $11.3 billion.

The NINCDS is the Federal focal point for all neurological research, including stroke. The Institute was established by P.L. 91-692 in 1950 and funded its first program projects and clinical research centers in stroke in 1961. Since the Institute's establishment, advances in the neurosciences have occurred at a rapid pace. Since 1950, the NINCDS has concentrated on establishing a well-trained cadre of basic and clinical sciences in the neurology field and the development of a new core of knowledge in the neurosciences. Based on these accomplishments, the Institute is now prepared to address exciting new areas of responsibility: the prevention of neurological disease and the restoration of brain function where damage has occurred.

This new emphasis by NINCDS holds much potential for further progress in the prevention and treatment of stroke. Much of the progress against stroke in the past fifteen years has come from the identification and treatment of the major risk factors for stroke -- high blood pressure, atherosclerosis, high red blood cell count and diabetes. Since 1972, the age-adjusted death rate for stroke has declined by 47.1 percent.

The NINCDS Stroke and Trauma program administers basic, applied and clinical research investigations, including multidisciplinary research centers, for cerebrovascular disease. The Stroke Program's primary areas of research and research training are as follows: cerebrovascular circulation (including stroke and vascular disorders and studies of prevalence, epidemiology, prevention, diagnosis, therapy and rehabilitation); degeneration and regeneration of damaged brain nerves; transplantation of tissue of the nervous system; and the study of positron emission tomography, nuclear magnetic rasonance and other imaging techniques, including assessment of research techniques for their clinical and diagnostic potential. Significant advances in the stroke field have and will occur as a result of NINCDS funding:

o In a recent major international clinical trial scientists discovered that a widely-used neurosurgical procedure to direct blood past obstructed brain arteries in stroke victims is no more effective than other available medical therapies for preventing stroke. The potential for savings from this valuable finding are great

-- it is estimated that this procedure costs an average of $15,000 and several thousand are performed in the United States each year.

- NINCDS is preparing to evaluate the effectiveness of another commonly-performed surgical procedure for the prevention of stroke -- the carotid endarterectomy.

- In the area of brain repair in the case of stroke, Institute-supported research has discovered that return of normal function 7 - 9 months after a stroke is not entirely due to the effects of rehabilitation; the brain has actually worked to repair itself. Investigations are proceeding to learn how to influence this naturally-occurring process to enhance its effects on the brain earlier to perhaps minimize damage caused by stroke.

The AHA is concerned that the recent Gramm-Rudman cuts and the President's proposed budget cuts for FY 1987 will have a devastating impact on the ability of NINCDS to continue many of its promising stroke research programs.

The President has proposed a 3.7 percent reduction in the NINCDS budget for FY 1987. The impact of this proposed level of funding on grants awarded by the Institute is tremendous. In FY 1985, the Institute awarded 722 research grants; in FY 1986, the Institute awarded 645 grants; under the President's proposed budget, only 538 research grants could be awarded. The Institute projects that its award rate in FY 1987 would be approximately 22.5 percent -- the lowest in NINCDS history.

While the number of research centers proposed to be awarded by NINCDS under the President's FY 1987 budget would remain the same as it is in FY 1986 -- 38 -- the level of funding for the centers program has been reduced by 8.7 percent. Funding for research contracts would be reduced by 8 percent allowing for only 60 rather than 64 contracts to be funded. The research training program would be held at its FY 1986 level of $12.6 million and 598 trainees and the intramural research and the research management and support functions of NINCDS would be given minimal increases, 1 percent and .6 percent, respectively.

With regard to the Institute's support for stroke research, AHA had been encouraged in FY 1985 to see a stronger emphasis placed on this highly important area of need. In FY 1985 support for stroke research increased 11.3 percent over the FY 1984 level. In FY 1986, support for stroke research increased only 2.3 percent over the FY 1985 level. Under the President's proposed budget, stroke research support would be reduced by 1.1 percent in FY 1987.

At a time when research in the neurological sciences is producing such exciting findings and clearly is accelerating our ability to treat and even prevent the occurrences of such life-threatening and costly diseases such as stroke, AHA believes that it is unwise to propose decreases in funding that the very programs that will continue to have a downward impact on the incidence of stroke and its debilitating consequences.

When asked what diseases within the NINCDS mandate are ripe for intervention at this time, during his recent appearance before the House Labor-HHS-Education Appropriations Subcommittee, Dr. Murray Goldstein, Director of NINCDS indicated that stroke clearly fit into this category. The AHA fully endorses Dr. Goldstein's assessment of the status of stroke research and would therefore like to recommend an appropriation for the NINCDS in FY 1987 of $479.3 million. This level of funding constitutes a 10.6 percent increase above the FY 1986 Congressionally-appropriated level for NINCDS.

DIVISION OF RESEARCH RESOURCES

Laboratory Animal Sciences Program

The Laboratory Animal Sciences and Primate Research program (LASPR) housed in NIH's Division of Research Resources (DRR), is responsible for supporting research projects that enable scientists to obtain and use animals effectively in health-related research. This is accomplished through grants which provide base support for the overall resources and a broad spectrum of multicategorical types of biomedical research conducted in seven Regional Primate Research Centers. The LASPR program also supports diagnostic laboratories, research manpower development in laboratory animal sciences, research on special nonanimal biomedical models, the improvement of laboratory animal facilities and other activities which support the various NIH programs.

In addition, The program advises NIH in the development of guidelines for the human care and use of animals in research and on the use of biomedical models which may lead to decreased use research animals.

The President's budget includes $38.9 million for the LASPR program for FY 1987. This is an increase of only 2.9 percent over the FY 1986 adjusted appropriation level and 1.6 percent below the FY 1986 Congressional appropriation for this program. Each of the program components of the LASPR program -- primate research centers, laboratory animal sciences and biological models and materials development -- will receive a minimal increase under the President's budget, however the Program will be funding the same number of research center grants, animal facilities improvement grants, individual and institutional training grants and contracts as it did in FY 1986.

AHA strongly believes that the LASPR program deserves a high priority for funding in FY 1986. The President's budget proposals for the DRR's animal program are highly out of line with its current needs. At a time when the public and scientific investigators continue to be concerned about providing the best possible care to research animals, it is essential that sufficient funding be provided for each of the LASPR's grant mechanisms. Therefore, AHA recommends that DRR receive a 10.6 percent increase over the FY 1986 Congressionally-appropriate level, or $370.5 million, in FY 1987.

Animal facilities and properly trained animal medicine personnel are a necessary aspect of all biomedical research activities. Furthermore, proper facilities and healthy animals help to ensure reliable research results. Our recommended 10.6 percent increase in DRR funding will only begin to meet the need for improving the wide-spread deterioration that currently exists in a majority of the research animal facilities located at biomedical research institutions in the U.S.

Biomedical Research Support Grant (BRSG) Program

The BRSG program was authorized in 1960 and it provides institutions heavily engaged in health-related research with a pool of flexible funds to meet particular needs determined by individual institutions not normally met by other PHS project grants. Allocating research funds on site allow research institutions to balance intervals needs to make the most effective use of emerging research concepts, techniques and talent.

The President's FY 1987 budget includes no funds for the BRSG program. We urge the Subcommittee to reject the President's proposal to eliminate this program. Our recommended funding level for the DRR for FY 1987, $370.5 million, would allow for continuation of this most important program.

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESSES

HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

DR. KENNETH BAKER, DIRECTOR, CARDIOVASCULAR MEDICINE, GEISINGER MEDICAL CENTER

Mr. NATCHER. We have our friend and colleague from Pennsylvania Mr. Paul Kanjorski.

Mr. KANJORSKI. It is a great pleasure for me to introduce one of my constituents, who is here to represent Geisinger Medical Center, a medical facility not just for central Pennsylvania, but a major health care force in the entire region of the Northeastern United States.

Dr. Kenneth Baker brings a wealth of knowledge and experience to today's hearing, and I urge my colleagues to evaluate his testimony carefully.

A 1974 graduate of the Temple University School of Medicine in Philadelphia, Dr. Baker has contributed greatly to his field of cardiology through his own numerous research projects and his commitment to teaching others in the medical profession.

Mr. Chairman, I am pleased to introduce Dr. Kenneth Baker of Danville, Pennsylvania.

Dr. BAKER. As Congressman Kanjorski said, I am Director of Cardiovascular Research Center, at the Geisinger Medical Center, located in central Pennsylvania.

Each year, more than 36,000 people are hospitalized at Geisinger-owned or managed hospitals and facilities. More than 500,000 outpatients visited Geisinger physicians last year alone.

Geisinger research efforts are an integral part of a comprehensive, multi-institutional system of health care that serves a region encompassing nearly 22,000 square miles.

On behalf of my colleagues at Geisinger, let me state our appreciation of this opportunity to present our views to this committee on fiscal year 1987 appropriations for the National Heart, Lung and Blood Institute, NHLBI.

I would like to preface this statement by emphasizing that Geisinger enthusiastically supports the activities of the National Institutes of Health, particularly NHLBI and its various programs pertaining to heart research.

We at Geisinger unequivocally support the Institute's commitment to fund the entire spectrum of research, both basic and applied; both for treatment and prevention. Under the able guidance of Dr. Claude Lenfant, that commitment continues.

Geisinger believes research is an essential component of medical advancement. Our staff members participate in clinical and basic research programs investigating cardiovascular, renal, malignant and gastrointestinal diseases.

In the cardiovascular area, Geisinger's researchers have pioneered studies involving a new hormonal receptor system in the heart.

Moreover, ground-breaking ceremonies in Danville, Pennsylvania, adjacent to the Geisinger Medical Center marked the first step in a $57,500,000 research initiative that will bring together senior investigators studying cellular and molecular biology.

The early work of researchers in this area, focusing on cardiovascular disease, could lead to the development of drugs to treat coronary artery disease or to prevent the onset of hypertension.

Under the able leadership of Claude Lenfant, that commitment continues.

It is well-known that cardiovascular disease is prevalent among Americans, young and old. Cardiovascular diseases afflict more than 60,000,000 people and cause almost 1,000,000 deaths each year.

Some 58,000,000 persons suffer from hypertension, 6,000,000 from coronary heart disease, and 2,000,000 from cerebrovascular disease.

Cardiovascular diseases are responsible for a loss of about $100,000,000,000 each year in productivity, wages and medical costs. Given this human suffering and economic consequence, it is imperative that NHLBI resources be expanded so that the current initiative in cardiovascular research can be maintained.

Geisinger's recommendations are aimed at maintaining this initiative. The desirability of exercising fiscal austerity should not supersede NHLBI's resources to continue its efforts in combatting the full panoply of cardiovascular diseases: Hypertension, cerebral vascular disease, coronary heart disease, arrhythmias, heart failure and shock, congenital and rheumatic heart diseases, cardiomyopathies and heart and circulatory system-infection.

To carry out its program, the Institute uses different mechanisms to accomplish specific objectives, including investigator-initiated research project grants, the mechanism used to support most of the basic and clinical research that makes up the important complement to research supported by investigator-initiated project grants is the Research Centers Program.

The Institute's Specialized Centers for Research, SCOR, programs in heart, lung, and blood diseases provide a unique environment for concentrating resources, facilities, and multidisciplinary expertise to conduct basic and clinical research.

These center programs are designed to produce rapid clinical applications of basic science advances. They continue to be successful.

An example is the Institute's Hypertension SCOR Program. Hypertension remains a major risk factor for coronary artery and cerebrovascular disease. Through its hypertension SCORs and investigator-initiated research project grants, the Institute is pursuing promising research leads on the basic mechanisms that regulate blood pressure, including the role of neurobiological factors, and elements in the diet such as sodium, calcium, potassium, and amino acids.

This research may increase the chances of controlling hypertension through diet and other nonpharmacologic measures.

Although the NHLBI has made considerable progress in the cardiovascular area, the battle against these diseases is far from over. New information should be used to learn new insights about cardiovascular diseases. Indeed, the Institute is pursuing several promising areas of basic research.

The recent revolution in recombinant DNA technology has opened doors for research that were inconceivable a few years ago. Investigations of genetics with the use of sophisticated DNA and monoclonal antibody techniques have had a significant impact on heart, lung and blood research.

Research to develop new pharmacological interventions continues to produce new knowledge.

Geisinger enthusiastically supports this ongoing research, and we applaud NHLBI supported research that has contributed to such achievements as open heart surgery, cardiovascular and respiratory intensive care units, diagnostic instruments for use in lung disease, and elimination of hepatitis B as a transfusion hazard.

Furthermore, we at Geisinger encourage the Institute to continue its prevention, education, and control efforts, particularly those programs that seek to reduce the prevalence of such risk factors as smoking, hypertension and elevated cholesterol levels.

The Institute's emphasis on prevention and continued support for basic research through individual project grants and research centers that makes prevention possible will continue to have a positive impact on death and disability that results from diseases of the heart, lung, and blood.

Given the demonstrated economic soundness of biomedical research activities, increased appropriation levels for NIH, and particularly NHLBI, should be a national priority.

Geisinger believes that in order for NHLBI to be able to continue to fulfill its mandate and provide the leadership which is crucial to our national biomedical research effort, an appropriation of $950,300,000 is necessary for fiscal year 1987.

In closing, I would like to quote Dr. Harold L. Foss, Surgeon-in-Chief of Geisinger Medical Center from its beginning in 1915 to 1958. Dr. Foss once said, "Medicine is never static; its leaders can never enjoy the luxury of inertia." These words are as true today as they were back in 1915.

Medical research cannot stand still. The Federal Government must not turn its back on biomedical advances of the future which could yield billions of dollars in health care savings.

On behalf of my colleagues at Geisinger, I thank you again for allowing us this opportunity to present our views.

Mr. NATCHER. Dr. Baker, you have made an excellent statement. We appreciate your appearance before the committee.

Mr. Kanjorski, do you have the old Dan Flood District?

Mr. KANJORSKI. Yes, I do.

Mr. NATCHER. Thank you very much.

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESS

DR. GORDON L. SNIDER, AMERICAN LUNG ASSOCIATION, AMERICAN THORACIC SOCIETY

Mr. NATCHER. Our next witness is Dr. Snider.

Dr. SNIDER. Thank you, I appreciate the privilege of being here to represent the American Lung Association and the American Thoracic Society, and I am the President-elect of the American Thoracic Society, and Director of the Pulmonary Center of the Boston University School of Medicine, and am a clinician and scientist responsible both for directing a clinical program, and a research program, and I am very pleased to say that our laboratories are on the sixth floor of a building that bears the name of the subcommittee member that is sitting to your right, Mr. Chairman.

It is a great pleasure for me to be here and to speak before Mr. Conte.

Mr. CONTE. Thank you very much, Doctor.

Dr. SNIDER. Now, the accomplishments in lung research that have made history in the last year or two are several. I would like to mention just three.

One is the discovery that the gene for cystic fibrosis occurs on the human chromosome 7, and gives the hope in the very near future of being able to identify whether children have the disease permitting appropriate action.

Another major advance is a trial currently in progress at the Clinical Center of the National Institutes of Health in which the protein Alpha 1 Protein Inhibitor is being given intravenously to sufferers from a deficiency of that disease, a disease which gives rise to the premature development of emphysema.

We have also seen the development in the last few years of an increasing number of substances called anti-elastosis, which may play a very important role in the future in preventing the development of chronic bronchitis and emphysema and in individuals who are smokers and have this disease and cannot stop smoking.

Despite the fact that we have made major accomplishments, the need for continuing our research effort is there. Chronic obstructive pulmonary disease, pneumonia and influenza are the fifth and sixth causes of mortality in the United States.

In contrast to the mortality from cardiovascular disease, which is falling, the mortality from chronic obstructive pulmonary disease and pneumonia and influenza is rising year by year.

Quite apart from the matter of pain and suffering, it is estimated that direct and indirect costs run between $35,000,000,000 and $40,000,000,000 a year.

I submit to you that we must maintain our research momentum in these areas.

I shall echo the comments of at least one previous speaker, my colleague, Dr. Ryan from Boston University, that the Lung Association too is distressed by the recent thrust of the Office of Management and Budget to become more directly involved in the management of the NIH.

Their specification of the number of awards and number of dollars to be spent in some 13 or 14 categories within each Institute, we think, presupposes an expertise which OMB does not have.

It is our belief that that expertise does reside in the NIH, and its advisory committees and councils, and that is where it belongs.

Flexibility in program management is essential. As you heard this afternoon, investigator-initiated or project grants make up the lion's share of the work at NIH and especially of the National Heart, Lung and Blood Institute.

A small amount of clinical research only is funded in those grants. The bulk of clinical research comes Special Centers of Research and from multi-center clinical trials funded by the contract mechanism.

It is terribly important in this era of fiscal stringency that we, or that the Institute directors working in concert with their advisory committees have the flexibility to maintain balanced programs, and especially to maintain clinical research activities.

For example, we are deeply concerned about the possibility that an intervention trial in chronic obstructive pulmonary disease, which is just completing its planning stages and about to enter work, and it may be cut, which is a program which is designed to document the importance of smoking cessation, to develop new methods, better methods of helping people to stop smoking and studying the effects of the administration of bronchodilator drugs in preventing the deterioration of lung function.

That program is in jeopardy, and we are deeply concerned. I want to speak now about a small program, the TB control program of CDC, which has been receiving $5,000,000.

We have recommended $10,000,000 for this year. It has played a tremendously important role in the communities throughout this land in helping to be certain that patients take the six to nine months of drug therapy which is necessary for the control of the infection, and making certain that the first treatment of a person's TB is the last treatment.

It has kept people out of the hospital and has been an investment which has brought back a return entirely out of proportion to the relatively small amounts of money which have been spent on it, and we urge its continuation.

Finally, I want to say something about the economic aspects of research, not as they relate to an alleviation of pain and suffering of patients, nor as they relate to saving medical care costs, but as they relate to our position in the world economy.

It is a slow and painstaking business to build research programs. They can be quickly destroyed. If we continue to ask researchers to build their programs down to meet budgetary needs rather than Congress and the Administration arranging for funding, so that program can be built up to their capabilities, I predict within the next decade we will become a second-rate power from the scientific point of view, and instead of developing drugs and new technology and exporting it, we are going to be importing it from Japan and Germany.

I will not go through our specific recommendations regarding funding, Mr. Chairman. Those are to be found in the written testimony which has been distributed to the committee members.

I very much appreciate the opportunity of having been allowed to appear.

Mr. NATCHER. Doctor, thank you very much, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Snider follows:]

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AMERICAN LUNG ASSOCIATION
The Christmas Seal People ®

STATEMENT OF GORDON L. SNIDER, M.D.

ON BEHALF OF

THE AMERICAN LUNG ASSOCIATION
THE AMERICAN THORACIC SOCIETY

TO THE

HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HHS, AND EDUCATION

APRIL 23, 1986

Mr. Chairman and Members of the Subcommittee, the American Lung Association and the American Thoracic Society, ALA's medical section, thank you for this opportunity to comment on the health and biomedical research programs in the FY 87 budget which are of particular concern to our lay volunteers, scientists, and health care professionals. I am Gordon L. Snider, M.D., President-elect of the American Thoracic Society. I am Director of the Pulmonary Center of Boston University School of Medicine and direct the clinical program in pulmonary disease of the School as well as its research program.

ALA/ATS will focus its concerns on those programs relative to the prevention and control of lung disease. These diseases constitute a devastating and growing health problem in the United States. Lung diseases range from the chronic and often fatal diseases of the newborn, to serious infectious diseases, to those related to environmental exposures--workplace and ambient air, and to diseases attributable to cigarette smoking--the leading cause of preventable death. When lung cancer and emphysema are included, lung diseases altogether rank third among the leading causes of death and sixth among the conditions responsible for premature retirement due to disabiltiy. COPD--Chronic Obstructive Pulmonary Disease--is the most rapidly increasing of the 10 leading causes of death. The direct and indirect costs of lung diseases will be a staggering $36.5 billion in 1985.

Grim as this statistical picture appears, it is not hopeless. Federal programs of disease prevention and health promotion, biomedical research, environmental and occupational health hazard control, and professional education and training have greatly improved the detection and treatment of many of these diseases. Furthermore, there are many exciting advances at the threshhold of translation into new diagnositic modalities.

The ALA/ATS has reviewed the lung related research, training, and demonstration programs for the National Heart, Lung and Blood Institute as well as for other institutes and agencies conducting activities related to the prevention and control of lung disease. Our recommendations are summarized below. The recommendations represent the best estimate, by physicians and scientists of the ALA/ATS, of the adequate resources necessary to continue these programs at the level of priority indicated by the magnitude of the lung disease problem.

Summary: FY 87 Health Appropriations Recommendations

National Heart, Lung and Blood Institute	$924.3 M
National Institute for Allergy and Infectious Diseases	$417.6 M
National Institute for Environmental Health Sciences	$212.8 M
National Institute for Occupational Safety and Health	$ 64.7 M
Tuberculosis Project Grants (Centers for Disease Control)	$ 10.0 M
Office of Smoking and Health	$ 5.0 M
Office of Health Promotion	$ 5.0 M

Our remaining comments, Mr. Chairman, will explore the resource needs of the National Institutes of Health, specifically the National Heart, Lung and Blood Institute. Additional comments will focus on the proposal to once again eliminate the program for Tuberculosis Project Grants administered by the Centers for Disease Control.

THE NATIONAL HEART, LUNG AND BLOOD INSTITUTE

The National Institutes of Health represent the largest source of funding for lung related research in the U.S. This research progarm--principally within the National Heart, Lung and Blood Institute--has contributed significantly to the remarkable progress made in the past decade towards unmasking the basic physiological events underlying the development of lung diseases, and devising treatments and preventive strategies for these diseases. Yet the President has proposed a budget of only $785.7 million for NHLBI, an 8.6% reduction from the FY 86 appropriated level.

The NHLBI research portfolio supports several research mechanisms. **Research Projects** support basic research and small-scale clinical studies. **Research Centers** are used to support multi-disciplinary research focused on major disease entities and to ensure that fundamental research outcomes are rapidly made available to the clinical arena. **Research and Development Contracts** are the best mechanism to support clinical trials and other population-based studies. The President's proposed budget would impact each of these mechanisms.

The Project Grant continues to be the keystone of the NHLBI research program. The largest portion of the research portfolio is dedicated to this mechanism. The President's proposed FY 87 budget contains only modest changes in this function--a reduction from the FY 86 appropriated level of 2704 competing and noncompeting grants to 2605 competing and noncompeting grants. This limited reduction in numbers of grants is in part due to the specific language in the FY 86 appropriations bill. However, the funding levels have been reduced by 7% which will require that noncompeting grants be negotiated downward an average of 11.3%. Reduction in the funding level of indivudual grants will have a significant impact on the ability of researchers to accomplish the goals set out in their grants. A reduction of this level may impair the scientific integrity of grants and in some cases, may make completion impossible.

A further problem related to the NHLBI budget is the growing imbalance in the research program. The distribution of funds among research mechanisms has markedly changed in recent years to the point where the Institute is no longer able to maintain a balanced program. For example, **Projects** received 58.3% of the total funds in 1980, growing to 71.9% in the President's proposed FY 87 budget. Centers were funded at 13.6% of the total NHLBI funds in 1980, declining to 10.9% in the President's proposed FY 87 budget. Contracts were funded at 17.3% in 1980, declining to 7.5% in the President's proposed FY 87 budget. As a consequesnce of these changes in distribution, the Centers and Contracts mechanisms may be severely compromised. A review of the President's proposed budget for these mechanisms demonstates this clearly.

The NHLBI supports 60 Specialized Centers of Research--SCORs. Of the 60 Centers provided for in the budget, 24 are scheduled for competitive renewal in FY 87. While the number of Centers to be funded remains stable, the funding level is reduced by 13% from the FY 86 appropriated levels. Further confounding this budgetary dilemma is the fact that Center awards are for a five-year period. During the renewal process significant budget growth is anticipated to counter previous inflation and to allow for adequate resources throughout the period of the award. The President's budget allows for $75.8M for this function. In actuality, the level of support should be, at a minimun, $93M to allow adequate budget resources and enable the Centers to achieve their research objectives.

The SCOR program is a unique research mechanism which includes both basic and clinical research emphasis to ensure that advances in the basic sciences are quickly translated into applications at the clinical level. This research mechanism direclty benefits patient and public health. A major reduction of this research mechanism will result in the slowdown of direct application of research findings and subsequent benefits to patients.

The NHLBI also supports a number of Clinical Trials through the Contracts mechanism. In the Division of Lung Disease, a major trial has been initiated to study Chronic Obstrucitve Pulmonary Disease--COPD, the most rapidly increasing of the 10 leading causes of death in the U.S. This trial represents an 8-year obligation by the NHLBI to determine if those persons considered to be most susceptible to the development of COPD can avoid these problems if they stop smoking, and to see if progression of their disease can be slowed by the use of certain bronchodilator medications.

The President's proposed budget shows a 3% reduction in funding from the FY 86 appropriated levels for this mechanism. This apparently modest cut is misleading. For example, during the first year of a trial, moderate costs are encountered as the study design and research protocol are developed. During the second year, major budgetary growth is necessary to absorb the costs related to equipment acquisition and patient recruitment--critical activities the COPD Trial is just entering. A level of funding for the Contracts mechanism of $75M would allow continuation of the current level of support. This amount, however, would still cause significant limitations in research activity.

A final issue with direct impact on the NHLBI research program is the lack of flexibility in program management. Since August 1985, the funds apportioned to the Institute are specified for each mechanism of support, with further specification of non-competing and new or competing awards. The inflexibility created by this process seriously limits the ability of NHLBI to manage programs to meet the changing research needs and priorities--a role the peer review process and Advisory Councils and Research Committees have addressed in the past. The process of requesting to reprogram the budget is a very slow and restricted one and as a consequence, some opportunities are missed. Further, the imbalance among support mechanisms is accentuated.

TUBERCULOSIS PROJECT GRANTS

Originally organized to combat tuberculosis, ALA/ATS continues its commitment to the eradication of TB. ALA is again surprised by the short-sighted action of the Administration to eliminate funding for this program. First authorized in 1982, TB Project Grants, administered by the Centers for Disease Control, provide cooperative agreements for TB control activities to state and local health departments in high incidence areas.

In 1980, 28,000 cases of TB were reported in the U.S., a 0.6% increase over 1979. Such an increase had been seen only twice in the past 25 years. A major contributing factor was the large number of cases diagnosed in the Indochinese refugee population. In 1981, the rate declined 6% to 27,373 cases and in 1982 a further decline of 7% was noted. This decline continued in 1983 and 1984 with 6.7% and 7.8% decreases respectively; decreases, noted by ALA/ATS, anticipated with an adequately functioning TB control program.

In 1985 it appears that once again there will be no decline in TB morbidity. Provisional data indicate that, if seen, the decline will be as little as 2%. Speculation is that once the data are finalized, this very small decline will disappear. In addition to the problems of drug resistant TB, TB among immigrants and refugees, and TB in children, new problems have emerged related to an increasing incidence of infection in those with the AIDS virus, and outbreaks among the homeless.

The program of TB Project Grants should be intensified in light of the current and emerging transmission problems rather than eliminated. Moreover, the program has undoubtedly saved third-party-payers millions of dollars in hospitalization costs. For example, Connecticut, Los Angeles, and Massachusetts report annual savings of $81,000, $500,000, and $250,000 respectively through the use of outreach workers and directly observed therapy.

CONCLUSION

The federal government provides a significant source of funding to a wide range of programs direclty impacting the prevention and control of lung disease. In the absence of adequate federal support, neither state nor local governments, nor the private sector are financially capable of continuing this level of programing. Furthermore, while it may appear tempting to assume that the private sector could be encouraged to accept some responsibility for support, this support might come at the high price of limited investigation or reversal of research direction.

Reductions to the extent proposed by the President will lead to the dismantling of the federal research program. This reduction would occur at a time when national and international industries are developing around our new biomedical technologies, negatively impacting on this economic growth. Great advances made over the last twenty years are now being capitalized upon in cell biology, molecular biology, and other biosciences. Past effort has clearly placed the U.S. in the forefront internationally and this level of effort must continue if our federal research program and supporting industries are to remain competitive.

The health and biomedical research programs of the federal government give strength and leadership to our entire health care system. We are now at the threshhold of remarkable breakthroughs in biomedical research which will lead to significant improvement in the health of the nation. Thus, now more than ever, vigorous support and adequate resources are essential.

WEDNESDAY, MAY 7, 1986.

NHLBI

WITNESS

DR. FRANCIS J. KLOCKE, PRESIDENT-ELECT, AMERICAN COLLEGE OF CARDIOLOGY

Mr. NATCHER. Our next witness is Dr. Francis J. Klocke, and we will be pleased to hear from you at this time.

Dr. KLOCKE. Mr. Chairman and members of the subcommittee, I am Dr. Francis J. Klocke, Chief of Cardiology at the State University of New York at Buffalo. I am pleased to participate in today's deliberations as representative of the American College of Cardiology, of which I am President-elect.

The College is a 14,000-member medical specialty society dedicated to the prevention and optimum treatment of cardiovascular disease. As such, the College is vitally interested in the research and training components of the National Heart, Lung and Blood Institute, NHLBI, and in the continued scientific progress of this vital Institute.

Mr. Chairman, allow me to begin by expressing the deep gratitude of the scientific research community for your own leadership and for the dedication of the subcommittee in supporting the National Institutes of Health in general, and the NHLBI in particular.

Your own backing during these difficult recent times has been an inspiration to all of us who look to the NIH for support and leadership.

Enormous progress has been made in the last 20 years in the effort to eradicate heart disease, but much remains to be done. The death rate for coronary heart disease in 1984 was only 60 percent of what it was in 1984.

Yet, in 1984, cardiovascular diseases continue to cause nearly half of all deaths. The decline in deaths related to cardiovascular disease has been more than three times faster than the decline for all other causes of death combined.

Still, some 58,000,000 people have hypertension, and 6,000,000 have coronary heart disease. In 1983, the economic cost of cardiovascular disease remained an estimated $102,000,000,000: $48,000,000,000 in direct health expenditures, $13,000,000,000 in indirect cost of morbidity, and $41,000,000,000 in indirect cost of mortality.

Still, in 1984, there were 740,000 fewer deaths from heart disease than would have occurred had the death rate not declined so dramatically. Clearly, the economic as well as the individual health benefits of research on heart disease can be enormous.

The President's fiscal year 1987 budget for NHLBI represents a significant and regrettable retreat from current support levels in a number of critical areas. Support for research training is marked for a 12.2-percent decrease in the coming fiscal year; that is, an almost $5,000,000 cut from current funding in the revised 1986 budget. This is a cut of 16 percent from that originally appropriated for 1986.

Although there may be adequate or even excessive numbers of practitioners in many areas of medicine, this is almost certainly not true in the research components.

A recent survey of cardiology training directors conducted by the American College of Cardiology revealed that 80 percent believe that additional numbers of cardiologists are needed in research and only 1 percent supported a decrease in the number of research cardiologists.

Physician researchers are pivotal to the success of our entire cardiovascular research effort, since they are able to give clinical relevance to basic discoveries and many are directly involved in patient-oriented research.

Despite the pressing need for new researchers, the proposed budget would deflate this effort enormously. We estimate that if the President's budget were approved, next fiscal year the number of unfunded meritorious National Research Service Award applications would be 164.

The long-range cost to the American health care system of discouraging this contingent of talented researchers from pursuing their goals would be extremely unfortunate and far-reaching. We would feel its effects well into the next century.

Another area singled out for particularly large cuts in the President's budget is the Specialized Centers of Research, SCOR, effort. SCORs were instituted to advance basic knowledge and to generate the most effective techniques and methods of clinical management and prevention in the areas of arteriosclerosis, hypertension, ischemic or coronary heart disease, thrombosis and blood resources.

Some 1200 research scientists receive some support under the SCOR program.

The Administration proposal for fiscal year 1987 would reduce funding by more than $7,000,000 for SCORs, an 8.5-percent cut from the 1986 revised budget. This would amount to a cut of over 12 percent from the original 1986 appropriations.

Such reductions would have severe consequences for ongoing SCOR initiatives including key research on arteriosclerosis and almost the entire clinical research program in children's lung diseases.

My written statement has other programs which would be deferred, if the President's cuts were to be imposed.

Great strides in the diagnosis and care of cardiovascular disease have been made, but important breakthroughs are still to come. We urge the Congress to continue to provide support for the efforts outlined above and not to jeopardize cardiovascular research and the future health of our people.

Indeed, we ask for a maintenance budget amount to last year's appropriated level of $848,600,000, plus 4 percent for inflation in all NHLBI program areas. We also ask that the subcommittee continue to resist efforts to rescind appropriated funds which, as an investigator, I can assure you is extremely damaging to carefully budgeted research projects.

In addition to the overall budget level, the ACC would like to address another issue which has become of vital importance to the mission of the Institute. Of course, the cornerstone of the Institute's portfolio has been the investigator-initiated grant, and this program has grown from 58 percent of the Institute's budget in 1980 to over 70 percent of the current extramural research budget.

However, one of the key aspects in the remarkable success of the NHLBI program has been a versatile and balanced approach to research funding, which has allowed the Institute's Advisory Committees and the Advisory Council to flexibly direct a portion of the budget toward research in particular vital areas.

Thus, several support mechanisms in addition to the investigator-initiated grants have been extremely successful, including the specialized centers, which carry out a large proportion of the clinical research, and the R&D contract mechanism through which clinical trials of new drugs or new procedures such as coronary angioplasty, as well as much work on the artificial heart can be funded.

I would just mention that we have suggested some specifics in our written statement that you might want to consider, to try and give the NHLBI Institute a little flexible range of funding, and we have also tried to call attention to the National Library of Medicine budget, which we believe deserves your support.

Mr. NATCHER. Dr. Klocke, thank you very much. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Klocke follows:]

TESTIMONY OF THE AMERICAN COLLEGE OF CARDIOLOGY (ACC)

ON FY 1987 APPROPRIATIONS FOR THE

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

presented by

Francis J. Klocke, M.D., F.A.C.C.
President-Elect
American College of Cardiology

before the

House Appropriations Committee

Subcommittee on Labor, Health, and
Human Services, Education, and
Related Agencies

May 7, 1986

Mr. Chairman, and members of the Subcommittee, I am Dr. Francis J. Klocke, Chief of Cardiology at the State University of New York at Buffalo. I am pleased to participate in today's deliberations as representative of the American College of Cardiology, of which I am President-Elect. The College is a 14,000 member medical specialty society dedicated to the prevention and optimum treatment of cardiovascular disease. As such, the College is vitally interested in the research and training components of the National Heart, Lung, and Blood Institute (NHLBI) and in the continued scientific progress of this vital Institute.

Mr. Chairman, allow me to begin by expressing the deep gratitude of the scientific research community for your own leadership and for the dedication of the Subcommittee in supporting the National Institutes of Health in general and the NHLBI in particular. Your ~~vigorous~~ backing during these difficult times has been an inspiration to all of us who look to the NIH for support and leadership.

Enormous progress has been made in the last twenty years in the effort to eradicate heart disease, but much remains to be done. The death rate for coronary heart disease in 1984 was only 60% of what it was in 1964. Yet, in 1984, cardiovascular diseases continue to cause nearly half of all deaths. The decline in deaths related to cardiovascular disease has been more than three times faster than the decline for all other causes of death combined. Still, some 58 million people have hypertension, and 6 million have coronary heart disease. In 1983, the economic cost of cardiovascular disease remained an estimated $102 billion: $48 billion in direct health expenditures, $13 billion in indirect cost of morbidity, and $41 billion in indirect cost of mortality. Still, in 1984, there were 740,000 fewer deaths from heart disease than would have occured had the death rate not declined so dramatically. Clearly, the economic as well as the individual health benefits of research on heart disease can be enormous.

The President's Budget

The President's FY 1987 budget for NHLBI represents a significant and regrettable retreat from current support levels in a number of critical areas. Support for research training is marked for a 12.2% decrease in the coming fiscal year, that is, an almost $5 million cut from current funding in the revised 1986 budget. This is a cut of 16% from that originally appropriated for 1986. Although there may be adequate or even excessive numbers of practitioners in many areas of medicine, this is almost certainly not true in the research component. A recent survey of cardiology training directors conducted by the American College of Cardiology revealed that 80% believe that additional numbers of cardiologists are needed in research and only 1% supported a decrease in the number of research cardiologists. Physician researchers are pivotal to the success of our entire cardiovascular research effort, since they are able to give clinical relevance to basic discoveries and many are directly involved in patient-oriented research.

Despite the pressing need for new researchers, the proposed budget would deflate this effort enormously. We estimate that if the President's budget were approved, next fiscal year the number of unfunded meritorious National Research Service Award applications would be 164. The long range cost to the American health care system of discouraging this contingent of talented researchers from pursuing their goals would be extremely unfortunate and far-reaching. We would feel its effects well into the next century.

Another area singled out for particularly large cuts in the President's budget is the Specialized Centers of Research (SCOR) effort. SCORs were instituted to advance basic knowledge and to generate the most effective techniques and methods of clinical management and prevention in the areas of arteriosclerosis, hypertension, ischemic or coronary heart disease, thrombosis and blood resources. Some 1200 research scientists receive some support under the SCOR program.

The Administration proposal for FY 1987 would reduce funding by more than $7 million for SCORs, an 8.5% cut from the 1986 revised budget. This would amount to a cut of over 12% from the original 1986 appropriations. Such reductions would have severe consequences for ongoing SCOR intitiatives including key research on arteriosclerosis and almost the entire clinical research program in children's lung diseases.

Many other research initiatives will be deferred or delayed if the President's 1987 budget is approved. These include the following:

o Studies of the impact of fatty acids in diet on the incidence of thrombosis and coronary heart disease.

o Important research on the artificial heart and circulatory assist devices.

o Studies of the cause and effect of blood pressure elevation in pregnancy. Hypertension in pregnancy is associated with 25,000 stillbirths and neonatal deaths, and 300 maternal deaths each year. Important studies are planned of the etiology and pathophysiology of the condition, characterizing the populations at risk, and studying the effects of antihypertensive medications upon mother and fetus.

- o Important studies of laser applications in cardiovascular treatment. The application of promising laser technology to the diagnosis and treatment of heart disease is in its infancy. Research is needed on the ability of laser technology to perform angioplasty, arterial welding, ablation of heart muscle for the control of certain arrhythmias, and other areas. Questions about the optimal amount of energy needed to perform these various procedures must be answered before clinical applications can go forward.

- o Studies of minimally invasive techniques to detect coronary artery lesions. Detecting, locating, and measuring the degree of narrowing in coronary arteries is essential in the clinical management of persons with coronary heart disease. Presently, this measurement is done by way of coronary angiography which employs injections into the major coronary arteries and the use of x-rays. The replacement of this procedure with a non-invasive one is a high priority for the cardiovascular community.

These are just a few of the many areas of research which will suffer in the proposed budget. Great strides in the diagnosis and care of cardiovascular disease have been made, but important breakthroughs are still to come. We urge the Congress to continue to provide support for the efforts outlined above and not to jeopardize cardiovascular research and the future health of our people. Instead, we ask for a maintenance budget amounting to last year's appropriated level of 848.6 million dollars plus four percent for inflation in all NHLBI program areas. We also ask that the Subcommittee continue to resist efforts to rescind appropriated funds which, as an investigator, I can assure you is extremely damaging to carefully budgeted research projects.

Mission of NHLBI

In addition to the overall budget level, the ACC would like to address another issue which has become of vital importance to the mission of the Institute. Of course, the cornerstone of the Institute's portfolio has been the investigator-initiated grant, and this program has grown from 58% of the Institute's budget in 1960 to over 70% of the current extramural research budget. However, one of the key aspects in the remarkable success of the NHLBI program has been a versatile and balanced approach to research funding, which has allowed the Institute's Advisory Committees and the Advisory Council to direct a portion of the budget toward research in particular vital areas. Thus, several support mechanisms in addition to the investigator initiated grants have been extremely successful, including the specialized centers, which carry out a large proportion of the clinical research, and the R and D contract mechanism through which clinical trials of new drugs or new procedures such as coronary angioplasty, as well as much work on the artificial heart can be funded.

A very serious problem with the use of these funding mechanisms has arisen because of the current practice of rigid specification by OMB of funding for each category. Therefore, we strongly urge that the Congressional budget allow some flexibility to the Institute staff working with its advisory groups. We recommend that a range of funding be allowed within the NHLBI appropriation for the major support mechanisms as follows:

Research centers: up to 12%
R and D contracts: up to 8%
Other (including training): up to 11%

This would allow maintenance of a minimum of 69% for research project grants. Such a range specification would provide the Institute with the extremely important ability to take advantage of research opportunities by reprogramming resources up to a specified percentage, and thereby to maintain its momentum in clinical research and training, as well as in fundamental research.

National Library of Medicine

The College would also like to take the opportunity to voice its strong support for the continuing operation of the National Library of Medicine (NLM), an integral and vital arm of the national research effort.

Established in 1836 with only a handful of medical texts, the NLM has grown into the world's largest medical research library, with over 3.5 million books, journals, technical reports, theses, photographs, and audiovisual materials. The American College of Cardiology through its Griffith Resource Library benefits directly from the NLM's Medical Literature Analysis and Retrieval System (MEDLARS) and its subcategory, MEDLINE. College staff and continuing medical education program participants can access the MEDLINE system of some 4 million medical citations through our in-house computer system, and can perform up-to-the-minute research on a multitude of medical subjects almost instantaneously.

In addition to its vast collections and innovative computerized retrieval systems, NLM is responsible for a number of other programs of national significance. These include a program of grant assistance for medical libraries, for training, and for research in biomedical communications. The NLM Regional Medical Libraries provide a nationwide system of convenient information centers.

The administration request of $56.4 million for NLM for FY 1987 represents a cut of $1.4 million below FY 1986 levels. We think this would be an unfortunate retrenchment in support for this important institution. The dispersal of research results to the practicing physician is an integral and often neglected aspect of the overall research effort. Knowledge gained which sits on a shelf is knowledge wasted and human suffering prolonged. We urge the Congress to maintain its present level of support for the NLM with a small increase of 4% for inflation.

Mr. Chairman and members of the Subcommittee, it is indeed a privilege to meet with you today on behalf of the American College of Cardiology. We look forward to continuing to work with the Subcommittee and its fine staff in our common effort to help those who are afflicted with heart disease, our nation's number one killer.
Thank you.

WEDNESDAY, MAY 7, 1986.

DEPENDENT CARE TITLE OF THE COMMUNITY SERVICE PROGRAMS AMENDMENTS

WITNESSES

HON. SALA BURTON, A REPRESENTATIVE FROM THE STATE OF CALIFORNIA

Mr. NATCHER. We have before the committee at this time our friend and colleague from California, Mrs. Sala Burton.

Mrs. Burton, if you will come right up to the table, we will be pleased to listen to you at this time. Before you give us your statement, as you heard me say before, when we would take our bill to the floor of the House, my friend Philip Burton would always join with us and help us pass this bill. When we start the bill, he would come down the aisle, put his hand on my shoulder and say, "Bill Natcher, I am with you all the way and I am going to help you." And he always did, and we are glad to have you before our committee.

Mrs. BURTON. Thank you, Mr. Chairman. I really appreciate those kind words.

Mr. NATCHER. Thank you.

Mrs. BURTON. I also want to apologize; I was supposed to be here earlier but I was in the Rules Committee working on the supplemental appropriation that is going to come up within the next couple of days.

Mr. Chairman, I appreciate the opportunity to testify today to request funding for the Dependent Care Title of the Community Services Programs Amendments of 1986, H.R.4421.

I would also like to express my sincere gratitude to the subcommittee and to you, Mr. Chairman, for providing the initial $5,000,000 which allowed this program to go forward. I have since then received a number of telephone calls from child care providers in my own Congressional District and other areas of the state. The providers expressed the same sentiments; they are very, very grateful.

The total amount of available funds was absolutely dwarfed by the number of latch-key children needing the care. They were extremely grateful for any amount and were comforted that the money would make its way to the communities that needed it the most.

Mr. Chairman, the response has been overwhelmingly positive. However, we are now faced with the need for additional funding for the coming fiscal year for the dependent care section.

As you know, the authorizing language was passed by the House last week. This program has wide bipartisan support. In the Senate, the proposed reauthorization of the Dependent Care Title will be set at $20,000,000 for each fiscal year. As you know, the same cost estimates are contained in the House bill, H.R.4421.

I encourage the subcommittee to approve the full $20,000,000, and I thank you very much, Mr. Chairman, for letting me come before this committee.

Mr. **Natcher**. Mrs. Burton, we want to thank you for your appearance. You have given us a good statement, and we appreciate it. Thank you.

Mrs. **Burton**. And I would like to, Mr. Chairman, put this statement in the record, if I could.

Mr. **Natcher**. It will be inserted in its entirety.

[The statement of Mrs. Burton follows:]

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COMMITTEE ON RULES
SELECT COMMITTEE ON HUNGER
DELEGATE
NORTH ATLANTIC ASSEMBLY

STATEMENT OF REP. SALA BURTON
before the
Appropriations Subcommittee
on Labor/Health & Human Services/Education
May 7, 1986

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to testify today to request funding for the "Dependent Care" Title of the Community Service Programs Amendments of 1986 (H.R. 4421). I would also like to express my sincere gratitude to the Subcommittee and to you, Mr. Chairman, for providing the initial $5 million which allowed this program to go forward.

As you may know, the Department of Health and Human Services recently issued the federal regulations governing the use and distribution of these funds. I have, since then, received a number of telephone calls from childcare providers in my own Congressional District and throughout the state of California. Almost to a person, the providers expressed the same sentiments. One: the total amount of available funds was absolutely dwarfed by the number of latchkey children needing care. Two: they were extremely grateful for any amount and were confident that the money would make its way to the communities that needed it most.

Mr. Chairman, the response has been overwhelmingly positive. However, we are now faced with the need for additional funding for the coming fiscal year for the "Dependent Care" section. As you know, the authorizing language was passed by the House last week.

When the Subcommittee on Human Resources held hearings on this program witness after witness testified about the great need for latchkey childcare services in their states. A provider in Polk County, Iowa stated in her testimony before the Subcommittee:

> "Although the state grants for dependent care planning and development are small, they will directly increase the supply of school age child care programs, facilitate the efficient use of the existing supply of all child care services and provide an incentive for local support. ...The state grants for dependent care planning and development does have the chance of multiplying locally. It will bring the child care resource and referral and school-age issues to the table and provide an incentive for state and local governments to include these issues on their agendas. In addition, it will provide an initiative for local and community organizations and employers to support the resource and referral and school-age needs of employed families."

This program was designed specifically to provoke this kind of community response. These funds are being used to establish latchkey programs for school-aged children in unused school facilities or community centers.

An additional benefit is the beginning of a progressive and cooperative relationship between the federal and state governments and local communities.

This is exactly the kind of cooperative arrangement -- one that combines federal, state and local support -- that the Administration encourages and supports. In fact, this program has wide bipartisan support. In the Senate, the proposed reauthorization of the Dependent Care Title will be set at $20 million for each fiscal year. As you know, the same cost estimates are contained in the House bill (H.R. 4421). I encourage the Subcommittee to approve the full $20 million.

Mr. Chairman, I feel strongly that this program will help to meet the needs of families of school-aged children. More than half of our workforce is comprised of women with children. They are a vital part of our economy. In the 1990's, economists predict, the United States will begin to experience a severe labor shortage due to a fall-off in the birth rate. The point is that we do not and will not have the luxury of choice. Most parents must work in order to provide for their families. This is not a trend, it is a permanent reality. The most important reality of all is, of course, our children, their safety and their well-being. This very modest program will help meet the needs of working parents and their children. What may be just as significant is the support it builds for childcare in the communities where it is needed. The provision of appropriate and adequate child care is best left to parents and communities -- which all have unique problems and approaches to solving them. This program provides a blueprint that is creative and cost-effective.

Once again, I urge the Subcommittee to approve the full $20 million and I appreciate the opportunity to testify here today.

# # #

WEDNESDAY, MAY 7, 1986.

DENTAL INSTITUTE

WITNESS

DR. ERLING JOHANSEN, DEAN OF TUFTS UNIVERSITY SCHOOL OF DENTAL MEDICINE, AND VICE CHAIRMAN, COUNCIL OF DENTAL RESEARCH OF THE AMERICAN DENTAL ASSOCIATION

Mr. NATCHER. Our next witness is Dr. Johansen.

Come around, Doctor. We would be pleased to hear from you at this time.

Dr. JOHANSEN. Mr. Chairman, and members of the subcommittee, I am Erling Johansen. I am a dentist and Ph.D. in pathology. I am the dean of Tufts University School of Dental Medicine in Boston, and I am also vice chairman of the Council of Dental Research of the American Dental Association.

I am appearing this afternoon in behalf of the American Dental Association, the American Association of Dental Schools, and the American Student Dental Association.

Today I would like to highlight the major areas of concern to our associations and with the permission of the subcommittee, submit a more detailed statement for the record.

First I would like to talk about dental research. In the past decade, impressive progress has been made in the prevention and control of dental disease. The effectiveness of our profession in improving the oral health of the public is demonstrated by the dramatic reduction of caries in children and the increased retention of natural teeth in adults.

These extraordinary health benefits to the public were made possible by the continued expansion of dental research. The progress made our understanding of the biology of the mouth promises that other dental diseases such as periodontal disease, herpes simplex and other diseases can be brought under control before very long if funding for the National Institute of Dental Research remains adequate.

The National Institute of Dental Research remains committed to achieving even greater reductions in dental caries than have already been accomplished. Emphasis must now be put upon tailoring prevention and treatment to individuals at high risk of developing decay.

Continuing research in these areas is vital to dentistry as it turns toward the challenge of preserving the natural dentition for a lifetime.

Last year Congress appropriated $103,000,000 for the National Institute of Dental Research. As a result of Gramm-Rudman, the Institute lost $4,500,000 from its appropriation. The President has asked that even greater reductions be made in 1987 shrinking the Dental Institute's budget to $96,500,000 and additional losses of $6,800,000.

Furthermore, if the President's budget is adopted, the number of new and competing dental research grants would be cut from 149 to 110.

It is our Association's belief that in order for the National Institute of Dental Research to maintain its current quality of dental research, it needs a minimum budget of $115,000,000 for fiscal year 1987.

The dental profession also urges the committee to restore full funding of the biomedical research support grant program. The BRSG program is used by research institutions for pilot studies to buy critically needed equipment, to provide early research support for new investigators, and to fund new and emerging research opportunities. Dental schools with small research programs would be especially hard hit.

Next I would like to turn our attention to student aid. Our Associations are very concerned that the limited funding provided to health professions education in recent years will result in reduced access to the health professions for qualified students from non-affluent backgrounds. The decline in Federal support for health professions education has paralleled an increased reliance on families to pay the cost of attending dental school.

In 1978, the average dental student's parent has a family income 12 percent higher than the national median family income. Dental students graduating last year came from families with incomes 30 percent higher than the estimated median family income of $28,000.

During the same time, the percentage of black students enrolled in dental schools remained steady but well below desired levels. While blacks represent 12 percent of the U.S. population, they made up only 4 percent of the 1985 graduating dental class.

A similar situation exists for Hispanic students who made up only 2.8 percent of the 1985 class even though Hispanics comprise 6.5 percent of the population.

Mr. Chairman, since 1981 health professions education funding has declined by 35 percent and that is on top of the approximately $50,000,000 that was cut out for capitation programs in the previous years. This is a severe strain on the dental education and research program.

We believe that unless this decline in Federal support for health professions education is halted, only students from affluent backgrounds will be able to attend dental school.

Furthermore, we fear that the number of minority students graduating from dental schools will continue to fall below the desired levels. Proper resources are necessary to see that this doesn't happen.

Our Associations urge the subcommittee to fund health professions education programs at the full authorized amount of $144,900,000.

Next I would like to consider the health education assistance loans. Here there is no outlay for the Federal Government and approximately 4,600 dental students last year made use of this resource and they borrowed $47,000,000.

Our Associations are very concerned that the program remain a viable loan of last resort for dental students.

We ask your assistance in assuring continued access to the program by inserting language in the fiscal year 1987 appropriations bill so that credit availability will not be restricted by the administration.

We are aware that there has been concern about defaults on the HEAL loans, but I am pleased to report that the American Dental Association and the American Association of Dental Schools are working with the Department of Health and Human Services in defining and resolving this issue.

A couple other items I would like to bring to your attention, Mr. Chairman. First, the Center for Disease Control and the dental disease prevention activity in that Center. We believe that the Center continues to provide a national focus for the control and prevention of oral diseases and conditions such as dental caries, periodontal disease and oral cancer.

This valuable national role includes providing consultation, training, promotional and educational support, disease surveillance, and other technical services to state and local governments and other professional education and citizen organizations.

Our Associations believe that the 1987 appropriation for the dental disease prevention activity should be at $1,200,000.

Finally, the National Center for Health Statistics: Last year, Mr. Chairman, we testified on behalf of the increased funding for the National Center for Health Statistics. As you know, this Center is the principal Federal agency for monitoring health status and providing essential information for developing health policies and strategies. We appreciated the increased funding Congress appropriated for last year for this activity.

During 1986, the Center will collect important data relating to visits to dentists, preventive dental practices and current public knowledge of dental diseases that are needed to organize and target dental care programs. The dental profession believes the center should be supported in 1987 by $70,000,000.

This funding level would allow it to continue its activities which have great significance to the delivery of dental care as well as other major health fields.

Mr. Chairman, on behalf of the three associations, the American Dental Association, the American Association of Dental Schools and the American Student Dental Association, I want to thank you for what you have done in the past for the whole profession of dentistry and we also appreciate this opportunity to come before you today to present our views.

Mr. NATCHER. Thank you very much, Dr. Johansen. You have given us an excellent statement. We appreciate your appearance.

[The statement of Dr. Johansen follows:]

STATEMENT OF
THE AMERICAN DENTAL ASSOCIATION,
THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS
AND
THE AMERICAN STUDENT DENTAL ASSOCIATION
ON
FY 1987 APPROPRIATIONS FOR
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. HOUSE OF REPRESENTATIVES
MAY 7, 1986

Mr. Chairman and Members of the Subcommittee:

My name is Dr. Erling Johansen. I am Dean of the Tufts University School of Dental Medicine, and serve as Vice Chairman of the Council of Dental Research of the American Dental Association. I am appearing today on behalf of the American Dental Association, the American Association of Dental Schools, and the American Student Dental Association. Today I would like to highlight the major areas of concern to our Associations and, with the permission of the Subcommittee, submit a more detailed statement for the record.

Dental Research

In the past decade impressive progress has been made in the prevention and control of dental disease. Dentistry's effectiveness in improving the oral health of the public is demonstrated by the dramatic reduction of caries in children and the increased retention of natural teeth in adults. These extraordinary health benefits to the public were made possible by the continued expansion of dental research. The progress made towards understanding the biology of the mouth promises that other dental diseases, such as periodontal disease and herpes simplex, can be brought under control before very long if funding for the National Institute of Dental Research (NIDR) remains adequate.

The NIDR remains committed to achieving even greater reductions in dental caries than have already been accomplished. Emphasis must now be put on tailoring prevention and treatment to individuals at high risk of developing decay, such as the handicapped, patients who have weakened immune systems or the elderly. Continuing research in these areas is vital to dentistry as it turns toward the challenge of preserving natural teeth for a lifetime. Sufficient funding is needed to attract dental researchers to carry out this work.

The proportion of dentists involved in research has drastically declined because the prospects for a career in dental research are so tenuous. A 1985 Institute of Medicine study reported that "full-time basic science faculty at dental schools declined by over 6 percent since 1982." NIDR's Dentist Scientist Award was established in 1985 to reverse this trend, but funding cuts are now endangering this very successful program. Originally, NIDR had planned to support 170 dentists in this program by 1989. However, current levels of funding allow no new candidates to be added to the program which only has 33 candidates.

Congress appropriated $103.3 million for NIDR for FY 1986. As a result of Gramm-Rudman, NIDR lost $4.5 million from its 1986 appropriation. The President has asked that even further reductions be made in 1987, shrinking NIDR's budget to $96.5 million, an additional loss of $6.8 million. Furthermore, if the President's budget is adopted the number of new and competing dental research grants would be cut from 149 to 110. Our Associations believe that in order for NIDR to maintain its current quality of dental research, it needs a minimum budget of $115.9 million for FY 1987.

The dental profession also urges the Committee to restore full-funding of the Biomedical Research Support Grant (BRSG) program. The President's budget cites this as a low priority program and proposes to begin phasing it out in FY 1987 with a $60 million funding cut. The BRSG program is vital to the dental research community. It is used by research institutions to support pilot studies, buy critically needed equipment, provide early research support to new investigators and fund new and emerging research opportunities. Dental schools with small research programs would be particularly hard hit.

Student Aid

Our Associations are most concerned that the limited funding provided to health professions education in recent years will result in reduced access to the health professions for qualified students from non-affluent backgrounds. The decline in federal support for health professions education has paralleled an increased reliance on families to pay the costs of attending dental school. In 1978, the average dental student's parents had a family income 12 percent higher than the national median family income. Dental students graduating last year came from families with incomes 30 percent higher than the estimated median family income of $28,000.

During this same time, the percentage of black students enrolled in dental schools remained level, but well below desired levels. While blacks represent 12 percent of the U.S. population, they made up only 4 percent of the 1985 graduating dental class. A similar situation exists for Hispanic students who made up only 2.8 percent of the 1985 class even though Hispanics comprise 6.5 percent of the population.

We believe that unless this decline in federal support for health professions education is halted only students from affluent backgrounds will be able to attend dental schools. Furthermore, we fear that the number of minority students graduating from dental schools will continue to fall below desired levels. Proper resources are necessary to see that this doesn't happen.

Mr. Chairman, since 1981 health professions education funding has declined by $38 million. When adjusted for inflation, this represents a 35 percent decrease. These significant reductions have occurred during a time of increased demands for primary care training, recruitment and retention of disadvantaged students, and geriatric initiatives. Our Associations urge the Subcommittee to fund health professions education programs at the full authorized amount of $144.9 million.

Although the Health Education Assistance Loan (HEAL) program requires no federal outlay, we are very concerned that the HEAL program remain a viable "loan of last resort" for dental students. Last year, approximately 4,600 dental students borrowed over $47 million through the HEAL program. We ask your assistance in assuring continued access to the HEAL program by inserting language in the FY 1987 appropriations bill that will address the following concerns:

1. Access to HEAL loans should be guaranteed up to the auhorized limit of $290 million plus any unused amount carried from prior years.

2. The total amount of HEAL credit authority should be required to be granted without apportionment or other similar limitations.

3. The Department of Health and Human Services should be directed to issue the proposed regulation on the HEAL program immediately.

We are aware that there has been concern about defaults on HEAL loans. ADA and AADS have made this a top priority. I am pleased to report that the representatives of our associations have formed a task force to work with officials from HHS. We are attempting to determine the severity of the problem and to develop strategies for prevention and reduction of HEAL defaults. We are confident that by working with schools, lenders and the Administration, a significant improvement can be achieved.

Dental Disease Prevention

Our Associations believe that the Dental Disease Prevention Activity (DDPA), of the Centers for Disease Control, continues to provide a national focus for the control and prevention of oral diseases and conditions such as dental caries, periodontal diseases and oral cancer. This valuable national role includes providing consultation, training, promotional and educational support, disease surveillance, and other technical services to state and local governments and other professional, educational, and citizen organizations. Additionally, it has assumed a key leadership, support and coordinating role in promoting heightened standards and practices for infection control in dentistry.

The DDPA works very closely with the American Dental Association and other major health organizations on an on-going basis and serves as a key advisor to the ADA Council on Dental Health and Health Planning, the Council on Dental Therapeutics, and the National Fluoridation Advisory Committee. In addition, the DDPA is co-sponosoring with the Association the 1986 National Conference on Infection Control in Dentistry, to be held in Chicago, May 13-14.

The continued involvement of the DDPA with the ADA in many areas of mutual interest is critical if the dental well-being of the American people is to be best served. The prevention of dental diseases has consistently been shown to be a good investment. Without a doubt, dental disease prevention efforts in the past have prevented much illness and functional disability and greatly enhanced the quality of life for the American public. In the process, many billions of dollars worth of repair and rehabilitation costs have been averted.

Our Associations believe that the 1987 appropriation for DDPA should be $1,196,900. This would allow the DDPA to continue ongoing critical services that have been essential for disease prevention.

National Center for Health Statistics (NCHS)

Last year, Mr. Chairman, we testified on behalf of increased funding for the National Center for Health Statistics (NCHS). As you know, NCHS is the principal Federal agency for monitoring health status and its relationship to other factors, and we appreciated the increased funding Congress appropriated for NCHS last year.

During 1986 the Center will collect important data about visits to dentists, personal preventative dental practices and current public knowledge of risk to dental disease. These data are needed to organize and target preventative care dental programs to the appropriate populations. NCHS must have the capacity to make timely and thorough analysis of these data, as well as those collected by other recent surveys, if they are to yield a return on the investment made in data collection.

Funds are needed in FY 1987 to prepare for the third cycle of the National Health and Nutrition Examination Survey (NHANES III) so that data collection can begin in 1988 as scheduled. From these data and others collected by this survey, the prevalance of major oral diseases and conditions, critical personal and social characteristics associated with oral health, the social impact of dental diseases and the relationship between oral and general health can be studied, thus providing a comprehensive approach to the measurement of health.

The dental profession believes that the Center should be supported in 1987 by $70 million. This funding level would allow NCHS to continue annual survey activities of sufficient depth to be useful to all major sectors of the health field.

OFFICE OF THE CHIEF DENTAL OFFICER

The position of Chief Dental Officer, of the U.S. Public Health Service is authorized by Congress in law. But in 1981 the Office of the Chief Dental Officer was abolished by the Department of Health and Human Services and the duties of the Chief Dental Officer were assigned to the Chief, Dental Services, Indian Health Service (IHS). This unilateral action has severely compromised the effectiveness of the chief dental officer.

Our Associations believe that the Office of the Chief Dental Officer should be included in the budget for the Office of the Assistant Secretary for Health as a separate line item. We believe that a budget of $460,000 is necessary to properly establish and properly staff this office.

As the Public Health Service's lead dentist, the Chief Dental Officer identifies oral health issues and proposes strategies to the directors of PHS agencies centers and offices, develops and recommends proposals for PHS oral health policies and positions, advances dental issues of PHS-wide significance, represents the position of the Service before national dental organizations and other Federal agencies and serves as the principal contact for oral health matters with dental public health counterparts in state health departments, other countries and the World Health Organization. As you can see, Mr. Chairman, the Chief Dental Officer has an important role in the Service, and to expect him to carry this out without any legitimate office or assistance is unfeasible.

Mr. Chairman, this concludes our statement. I would be happy to attempt to respond to any questions which the Subcommittee may have.

WEDNESDAY, MAY 7, 1986.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

WITNESSES

DR. ANDRZEJ BARTKE, PRESIDENT, SOCIETY FOR THE STUDY OF REPRODUCTION

DR. HOWARD BRINKLEY, WASHINGTON REPRESENTATIVE, THE SOCIETY FOR THE STUDY OF REPRODUCTION

Mr. NATCHER. Our next witness is Dr. Andrzej Bartke.

Come around, Dr. Bartke. You have with you Dr. Brinkley, and, Dr. Brinkley, it is a pleasure to have you back before the committee.

Mr. BRINKLEY. Thank you, sir.

Mr. NATCHER. We will be pleased to hear from you, gentlemen.

Mr. BARTKE. Mr. Chairman, I am Andrzej Bartke, professor and chairman, Department of Physiology, Southern Illinois University School of Medicine in Carbondale, Illinois. I am a reproductive biologist specializing in the hormonal control of the male reproductive system.

My primary area of research is the study of the effects of a pituitary hormone, prolactin, on male reproductive functions. In addition to conducting research, I teach medical students and train young men and women to conduct original research independently.

I am appearing before your committee today as President of the Society for the Study of Reproduction. The Society has a membership of 1800 comprised predominantly of research scientists from universities, medical schools, and nonprofit and governmental research institutes who conduct fundamental and applied research. Our scientists also train young people to become the basic and clinical researchers in reproductive biology.

All of our members seek a fundamental understanding of the normal structure and functioning of the male and female reproductive systems and the mechanisms by which the reproductive systems are controlled. Some members of the Society conduct developmental research to determine the potential of our basic knowledge for solving one or more of society's reproduction problems.

Some members exploit the basic knowledge by developing new and improved forms of human contraception, by overcoming various forms of human male and female infertility, by improving the quality of offspring born to parents, and by developing diagnostic techniques for determination of normal development.

A few of our members employ advances in our basic understanding of the mechanisms which control the male and female reproductive systems to improve the production of high quality animal protein with which to supplement the diets of humans around the world.

Few disciplines conduct research which touch the lives of so many. Control of reproductive by contraception in the human permits couples to delay parenthood until a child is desired and to limit the size of the family. It is obvious that limiting the size of the family has important economic consequences.

Conversely, advances in understanding of male and female infertility have led to methods of treating infertile couples who prefer their own children to children obtained through the adoptive process.

Although such methods are commonly practiced now for some types of infertility, vast improvements are needed in techniques that are less costly and less invasive of the mother-to-be. The success of such techniques already has led to more fulfilling relationships among couples and to happier families.

Most of these advances offer an increase in the quality of life for responsible parents and for their children. They also reduce the cost of medical care and social welfare funding for children and adults of unintended pregnancies.

Although the contributions of reproductive research seem obvious and progress in the solution of these problems continues, further progress can come only through additional research. For example, not all contraceptives are acceptable to all people. Not all contraceptive methods are equally effective nor equally easy to use.

Fertility technology is really in its infancy in solving some forms of infertility and cannot solve others at all. Diagnostic techniques for determining fetal normalcy and normal progress of pregnancy are being developed, but surgical and chemical techniques for timely and appropriate corrective intervention are not yet available.

Nutritional requirements and development of nutritional therapies are still under investigation for western society. Protein deficiencies in diets of pregnant mothers and infants are epidemic in many parts of the world, and remain a problem in individual cases in the United States.

Thus, it is extremely important that increased funding of reproductive research continue. Unfortunately, attempts to solve the balance of trade and Federal deficit problems have put enormous pressure on all elements of the Federal budget, but more so on those elements of the budget which are not protected by entitlement laws.

In addition, not so obvious fiscal pressures are being brought to bear on the research enterprise in reproductive biology and its sister biomedical sciences. For example, several laws have been passed recently that require extensive upgrading of animal care facilities. These are good and necessary laws.

However, such upgrading is expensive, and will consume a larger portion of the funds normally devoted to other aspects of research projects. In addition, funds will be required to hire additional personnel to administer the laws, and much time of scientists will be taken away from research to review protocols, monitor compliance, et cetera.

Now I would like to come to an area that is dear to me, and this is the education. The present leadership of the United States in biomedical research depends on the continued influx of young talented people into this discipline.

The uncertainties of research funding are known to even the undergraduate students throughout the nation. They can hear principal scientists and young postdoctoral scientists discussing the problems of research funding and the effort required to function successfully in such an atmosphere.

These uncertainties have led many of our brightest young people to choose careers which appear to offer greater opportunity for success and stability in their professional lives. Reversal of this very alarming trend is vital for assuring that the best possible research will continue to be conducted in our laboratories and that the United States will continue to lead the world in biomedical research.

We recommend that the appropriation of funds for support of programs of the National Institute of Child Health and Human Development in the amount of $317,000,000. We are aware that the amount requested is greater than the amount recommended by the President, but believe the need for greater funding is clear.

In the past, this committee has been the strongest supporter of programs in reproductive and we appreciate the leadership role the committee has taken in bringing health to the nation. We look to your strong leadership again this year.

Our members thank you for this opportunity to discuss the needs and successes of our scientific discipline. We would be happy to answer any questions you might wish to ask.

Thank you very much.

Mr. NATCHER. Thank you very much, Dr. Bartke.

[The statement of Mr. Bartke follows:]

TESTIMONY
OF THE
SOCIETY FOR THE STUDY OF REPRODUCTION
BEFORE THE
SUBCOMMITTEE ON APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES AND EDUCATION

AT

2:35 P.M. ON MAY 7, 1986

BY

Dr. Andrzej Bartke, Ph.D.

President of the Society, and Professor and Chairman

Department of Physiology, School of Medicine, Southern Illinois University,

Carbondale, Il 62901

and

Dr. Howard J. Brinkley, Ph.D.

Washington Representative of the Society, and Professor

Department of Zoology, University of Maryland,

College Park, MD 20742

Telephone Number: AC 301-454-5270

Mr. Chairman and members of the committee:

I am Andrzej Bartke. I am Professor and Chairman of the Department of Physiology, Southern Illinois University School of Medicine, Carbondale, Illinois. I am a reproductive biologist specializing in the hormonal control of the male reproductive system.

My primary area of research is the study of the effects of a pituitary hormone, prolactin, on male reproductive functions, particularly the steroidogenic and gametic functioning of the testes. We also study the effects of marihuana on gonadal function and behavior in the male. In addition to conducting research, I teach medical students, and train young men and women to conduct original research independently.

I am appearing before your committee today as President of the Society for the Study of Reproduction. The Society has a membership of 1800 comprised predominantly of research scientists from universities, medical schools, and nonprofit and governmental research institutes who conduct fundamental and applied research. Our scientists also train young people to become the basic and clinical researchers in reproductive biology.

All of our members seek a fundamental understanding of the normal structure and functioning of the male and female reproductive systems and the mechanisms by which the reproductive systems are controled. Some members of the Society conduct developmental research to determine the potential of our basic knowledge for solving one or more of society's reproduction problems. Some members exploit the basic knowledge by developing new and improved forms of human contraception, by overcoming various forms of human male and female infertility, by improving the quality of offspring born to parents, and by developing diagnostic techniques for determination of normal development. A few of our members employ advances in our basic understanding of the mechanisms which control the male and female reproductive systems to improve the production of high quality animal protein with which to supplement the diets of humans around the world.

Few disciplines conduct research which touche the lives of so many. Control of reproduction by contraception in the human permits couples to delay parenthood until a child is desired and to limit the size of the family. It is obvious that limiting the size of the family has important economic consequences. The family can provide better food, shelter, health care and education for the children and under less stressful circumstances. The children should be healthier and happier.

Conversely, advances in understanding of male and female infertility have led to methods of treating infertile couples who prefer their own children to children obtained through the adoptive process. Although such methods are commonly practiced now for some types of infertility, vast improvements are needed in techniques that are less costly and less invasive of the mother--to-be. The success of such techniques today has led to more fulfilling relationships among couples and to happier families.

Development of diagnostic techniques for the determination of the normalcy of the fetus and for monitoring the normal progress of a pregnancy has led to the possibility of correcting anatomical and physiological deficiencies in children at earlier stages of development so that normal, or more normal, development can continue for longer periods post-correction. The earlier the correction is completed the greater the probability of normal adulthood for the child, and the lower the probablility of need for expensive life-long medical support.

The normal development of a new life depends on an organic component of the human diet that is scarce in most of the world -- high quality protein. Development of the embryo in the mother and the normal development of the child after birth depends on a balanced dietary intake. Reproductive biologists are using their knowledge of reproductive mechanisms to increase the supply of high quality protein from domestic animals and fish to for human populations everywhere.

Most of these advances offer an increase in the quality of life for responsible parents and for their children. They also reduce the cost of medical care and social welfare funding for children and adults of unintended pregnancies.

Although the contributions of reproductive research seem obvious and progress in the solution of these problems continues, further progress can come only through additional research. Not all contraceptives are acceptable to all people. Not all contraceptive methods are equally effective nor equally easy to use. Fertility technology is in its infancy in solving some forms of infertility and cannot solve others at all. Diagnostic techniques for determining fetal normalcy and normal progress of pregnancy are being developed, but surgical and chemical techniques for timely and appropriate corrective intervention are not yet available. Nutritional requirements and development of nutritional therapies are still under investigation for western society. Protein deficiencies in diets of pregnant mothers and infants are epidemic in many parts of the world, and remain a problem in individual cases in the United States.

Thus, it is extremely important that increased funding of reproductive research continue. Unfortunately, attempts to solve the balance of trade and federal deficit problems have put enormous pressure on all elements of the federal budget, but more so on those elements of the budget which are not protected by entitlement laws.

In addition, not so obvious fiscal pressures are being brought to bear on the research enterprise in reproductive biology and its sister biomedical sciences. For example, several laws have been passed recently that require extensive upgrading of animal care facilities. These are good and necessary laws. However, such upgrading is expensive and will consume a larger portion of the funds normally devoted to other aspects of research projects. In addition, funds will be required to hire additional personnel to administer the laws, and much time of scientists will be taken away from research to review protocols, monitor compliance, etc.

Similar federal and state rules and regulations have become effective for control of biological hazards, chemical hazards, and radiation hazards. These laws seek to protect mankind and the environment and are supported by scientists, but they also constitute additional costs of conducting research that may not be offset by additional funding.

Another consideration is the threatened reduction in indirect costs that can be charged to research grants and contracts. Indirect costs normally support the costs of complying with laws regarding hazards to man and amimal. Loss of these indirect cost funds will lead to reductions in the support for the research enterprise.

The recent assessment of the status of scientific instrumentation and equipment in the United States has documented the need for funding of the upgrading, replacement and maintenance of much of the scientific instrumentation and equipment presently being used in the conduct of scientific research.

Continued funding of the purchase of state-of-the-art technologically advanced instrumentation is essential to the efficient and effective conduct of biomedical research and to the training of young men and women in the science of reproductive biology.

The present leadership of the United States in biomedical research depends on the continued influx of young talented people into this discipline. The uncertainties of research funding are known to even the undergraduate students throughout the nation. They can hear principal scientists and young postdoctoral scientists discussing the problems of research funding and the effort required to function successfully in such an atmosphere. These uncertainties have lead many of our brightest young people to choose careers which appear to offer greater opportunity for success and stability in their professional lives. Reversal of this very alarming trend is vital for assuring that the best possible research will continue to be conducted in our laboratories and that the United States will continue to lead the world in biomedical research.

We recommend that the appropriation of funds for support of programs of the National Institute of Child Health and Human Development in the amount of $317 million dollars. We are aware that the amount requested is greater than the amount recommended by the President, but believe the need for greater funding is clear. In the past, this committee has been the strongest supporter of programs in reproduction and we appreciate the leadership role the committee has taken in bringing health to the nation. We look to your strong leadership again this year.

Our members thank you for this opportunity to discuss the needs and successes of our scientific discipline. We would be happy to answer any questions you might wish to ask.

Mr. NATCHER. Dr. Brinkley, it is always a pleasure to have you back before the committee. We want to thank you. Dr. Brinkley, would you like to say a word?

Mr. BRINKLEY. Only to endorse very strongly what Dr. Bartke has said.

He mentioned very briefly some of the more subtle effects on funding that I feel are probably going unnoticed by the appropriations process. He mentioned one that is very critical, animal care facilities, caging and things of that sort that are necessary. The costs of that are going to be astronomical.

Compliance in terms of time involved and so on will be very important in reducing productivity among existing scientists, but there are equally as numerous laws on chemical hazards, radiological hazards and other environmental concerns that take time of existing scientific staff and impinging upon research programs and divert energy away from productivity.

We also, a part of the very important aspect of grant funding for university scientists in that much of this is supported by indirect cost. As you know, the Office of Management and Budget has been threatening, if not actually acting, to reduce the indirect cost rate to 25 percent or so, and make it uniform.

What is not clearly understood is that much of the real cost of conducting research as a result of additional laws that have been passed which are normally going unnoticed as a real cost are actually tied up in the indirect cost rate. As a result, they could lead to impingements on direct cost moneys that scientists would receive.

So it is not clear-cut that you can simply cut the indirect cost rate and have a net improvement in the amount of funding available for research. Someone has to pay for the monitoring of these other requirements that are upon us, and improving on the quality of the facilities.

So the problem is much greater than we normally hear about, because there are more subtle and indirect ways in which cost of research are actually rising greater than the rate of gross national product/price deflator that is normally used in the biomedical research area.

Most of this, of course, will eventually affect support levels for young people coming into the field and reduce the attractiveness of pure basic research as well as clinical research as a career area for selection. It has already begun to show.

So it is a serious consideration, and I will try to develop that in more detail separately with your staff.

Mr. NATCHER. Thank you very much, Dr. Brinkley.

Gentlemen, we appreciate your appearance.

WEDNESDAY, MAY 7, 1986.

NICHD

WITNESS

JOHN W. GAGE, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, LOCAL 1923, AFL-CIO

Mr. NATCHER. Our next witness is Mr. John Gage.

Come around, Mr. Gage. Mr. Gage, we will be pleased to hear from you at this time.

Mr. GAGE. Thank you, Mr. Chairman.

I have two statements I would like to enter for the record. One is on the appropriations for the health care financing, and the other for social security.

I would like to talk for a few minutes on the social security appropriation. Last year you know your committee saw fit to enter 1,000 FTEs and $30,000,000 into the appropriation which Gramm-Rudman certainly took care of for us along with overtime, training money, travel, or temporary employees.

This year the Agency is coming back with an additional reduction which is very much on target with the OMB staffing reduction report that surfaced in 1984. We will be 4,000 FTE down after this year from the 1985 budget.

Much of the staffing reductions are being justified by the systems modernization going on in society security. There is another side to the modernization that we would like to show you.

We have included some documents in our report. Basically, the modernization is broken into two parts, the front end, which is the claims-taking on the screen, and the back end, which is the benefit computation part.

The front end is probably the easiest; it is the terminal acquisitions. This phase of the modernization has recently been backed off for 14 months.

The back end of the modernization, which is the benefit computations, is the much more difficult relying on contractors and very intricate software. Recently, release 3, which the back-end software, was submitted to the operating components for comments. We included a number of drafts of these comments in our report.

Let me just quote on. This is from the regional commissioner of New York.

Our general reaction to release 3 was disappointment because it did not meet our expectations of the system's redesign. In most respects, the specifications adequately defined a MCS process to replace the current caps, but these specifications simply duplicate the existing system with most of its current limitations and inadequacies.

Virtually every comment from the user community said the same thing—highly satisfied with the software proposals on the back end.

Our point in making this presentation and criticism of the modernization is that the modernization companies not justify these staffing cuts. The staffing cuts are rolling on target, the modernization is limping along and not picking up the slack.

SSA is now turning to a number of expediencies to meet staffing reduction targets. For instance, a number, I think about 400 FTEs, are claimed to be saved by reducing development that our district office employees give to beneficiaries in developing their claims. That is not the type of thing that will keep service delivery on the level that it is.

You know, reducing the help given to citizens when they come in to get their claims work is going to turn us into more of an adversary relationship with beneficiaries than the one that we currently have where employees try to make sure that beneficiaries receive every benefit under the law.

A second expediency which has a big 1,000 FTEs attached to it is a thing called DOFA, District Office Final Authorization, expansion. What this expediency calls for is about 14 percent of the claims—the difficult claims, workmen's comp, attorney cases, or work in the program service centers by claims authorizers, the equivalent of claims reps in the field.

To take 1,000 FTEs, what has happened and this is scheduled for July 1986, that these cases will simply be dumped on the district offices to work. The reason they have not been worked there is because the district office is not conducive to working these complicated time-consuming cases.

The way it was done is even worse. The office assessment changed the error definition in the winter of 1984, did a three-month study on a very minus schedule amount of cases and said that accuracy would not suffer. The claims people who work these cases are in an uproar because the accuracy most certainly will suffer not to mention that 1,000 valuable employees will lose their positions.

Things like this are not part of the systems modernization. These are just short-cuts that will impact on service delivery.

GAO is doing a report on the modernization which is to be released, I think, this summer, which I am sure will hit on another problem with the modernization, and that is the contracts. I think we are through the scandalous part, at least I hope we are, of the contracts situation at social security.

However, now an even greater problem is surfacing. The work of the contractors is coming back. Our people are looking at it and seeing that it is woefully deficient, not what they were paid to do. Much has to be reworked.

These types of expediencies in this current state of the modernization we don't think justifies the staffing cuts if service delivery is to be maintained.

We are getting a new commissioner in with the accompanying inevitable, I guess, reorganization and senior executive shake-ups.

What we are asking, Mr. Chairman, last year we tried intent language and you put additional FTEs and money into the appropriations and it was simply bypassed. We would like the Chair and the committee to consider a personnel floor for society security.

The modernization cannot be justified to take these staff cuts, and we really see a confrontation coming down the road when the staff cuts, the modernization, budget cuts, all come into play.

We would also like to, if you would, investigate closely the expediency of the DOFA expansion. We would like to see GAO brought in to review the reasoning for SSA for making this move.

But these two points are what we ask you to consider—the GAO investigation of DOFA and your consideration of a personnel floor for society security at the 1985 level.

Thank you.

Mr. NATCHER. Thank you very much, Mr. Gage. We appreciate your appearance before the committee. You, too, have given us an excellent statement.

[The statement of Mr. Gage follows:]

STATEMENT OF

JOHN W. GAGE
PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
LOCAL 1923, AFL-CIO

ON

HCFA APPROPRIATIONS

BEFORE THE

HOUSE COMMITTEE ON APPROPRIATIONS

MAY 7, 1986

Mr. Chairman and Members of the Committee, I am pleased to place these extended remarks into the record concerning the budget allocation for the Health Care Financing Administration (HCFA). Our local represents the Federal employees who are stationed at HCFA headquarters offices in Woodlawn, Maryland and Washington, D.C.

Before I focus on the specific appropriations of concern to us, I will briefly mention the impact of the Gramm-Rudman-Hollings legislation on current operations.

Medicare Contractors

The Gramm-Rudman-Hollings sequestration required reductions of $18.6 million in claims processing costs, $8.9 million in payment safeguard activities, and $12.9 million in productivity investments. The claims processing reduction is causing an increase in the days work in process from [illegible] days to 32 days for Part A and from 11 days to 36 days for Part B. It also eliminated funding for system modifications to capture additional information for use by Peer Review Organizations (PROs) and reduced overpayment recovery activities. In payment safeguards, the fiscal intermediaries were required to substantially eliminate audits for home health agencies, skilled nursing facilities, hospices, End Stage Renal Disease facilities, and hospitals that are not on prospective payment. The reduction in productivity investments will require the contractors to delay implementing the designated regional intermediary system for home health agencies and the on-line query system for health maintenance organizations. It also caused the elimination of investment in system security safeguards by the contractors. The deferred eliminated an additional $2.1 million for claims processing activities.

STATE CERTIFICATION

The $2.2 million sequestration for State Certification required reduced survey coverage levels for home health agencies, ESRD facilities and laboratories. Out of a total of 6,315 surveys, 890 (approximately 14 percent) were eliminated.

PEER REVIEW ORGANIZATIONS (PROs)

The sequester reduced funds set aside to award new contracts for PRO areas terminated because of poor performance and slowed the issuance of change orders to carry out new review activities. The Agency is forced to rely on fiscal intermediaries to carry out mandated review activities in areas without PRO coverage and will require the intermediaries to absorb these costs within their funding authority for medical review.

RESEARCH AND DEMOSTRATIONS

The reduction in Research and Demonstrations will prevent HCFA from funding any new research awards in FY 1987. Funding is available for continuations of existing projects only. This will severely and adversely impact HCFA's ability to foster the restructioning of Medicare and Medicaid payment and health care delivery systems.

ADMINISTRATIVE COSTS

As a result of the sequestration, the Agency was unable to fund 1[illegible] full-time equivalents within the approved personnel ceiling, will eliminate selected management support contracts, and will reduce funding for other activities such as travel, training, overtime, awards, etc. by 25 percent. The major impact has been to reduce review and oversight of the fiscal intermediaries, PROs, and state survey agencies, and it has eliminated part of the Agency's efforts to improve its automated data processing capability. These actions have resulted in an austere level of operations, but there have not as yet been any furloughs.

GRAMM-RUDMAN II

If a second sequestration occurs for Fiscal Year 1987 we can expect staff cut backs at the 20% level. This will not be able to be accomplished without furloughs and an early out window.

PROPOSED 1987 BUDGET

The FTE ceiling as proposed by the Administration for FY 1987 is 3,757. We support an increase in this figure by 43 full-time equivalents as originally requested by the Department, for a ceiling of 3800.

MEDICAID OVERSIGHT RESPONSIBILITIES

Of the Total staff of 442 employees of the Bureau of Program Operations, less than 50 are currently employed in Medicaid Oversight responsibilities. The current Administrations philosophy is "The States have a right to make their own mistakes". The problem with this approach is often times they are making the mistakes with Federal dollars.

In general the impact of this approach is:

* Reduced ability to improve and uphold disallowances;

* probable increase in actual eligibility errors not reflected in measured error rates.

* weakened program administration (due to diminished Federal presence)

* lessened ability to commit budget savings beyond FY 1986

Additional resources are needed for Federal financial management and oversight and Third Party Liability Recovery. Additionally, we remain opposed to any "cap" on Medicaid. If a cap were imposed those stats who have expanded services and eligibility groups over the last several years would be the ones most hurt.

SINGLE SITE LOCATION FOR HCFA

Several years ago this Committee appropriated 1[illegible] million dollars to fund a search by HCFA and GSA for a single site location for the headquarters for this Agency. The Agency spent the money but our employees are still housed in ten different buildings in two different cities. Several of the buildings are substandard and were not intended to house large numbers of employees. The consolidation of HCFA that began with the July 1979 relocation of most Washington - based employees to Woodlawn was never completed. We urge the Committee to follow-up with the Agency on this issue.

HCFA PROGRAM MANAGEMENT

The Department had requested $222.6 million for administrative costs for FY 87. OMB reduced this request by 7.4 million to $215.2 million. We recommend to the Committee that the original figure be restored. The Agency now suffers critical staffing shortages in accountants, actuarys, computer analyst, auditors, secretaries and other technical support personnel. The cut should be restored with the aim to hire needed personnel.

I appreciate this opportunity to submit our remarks for the record. We would be happy to supply any additional information the Committee Chairman might need.

STATEMENT OF

JOHN W. GAGE
PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
LOCAL 1923, AFL-CIO

ON

SSA APPROPRIATIONS

BEFORE THE

HOUSE COMMITTEE ON APPROPRIATIONS

MAY 7, 1986

On March 17 GAO delivered a report to Senator Weicker entitled "Actions and Plans to Reduce Agency Staff". In that report, GAO examines the Agency's systems enhancements and accompanying staff reductions and concludes that, "Overall, SSA's projections of savings from these initiatives are largely tentative, according to agency officials. Further, in many cases, it appears to us they may not produce the savings when or to the extent originally anticipated."

Most of the modernization to date has focused on the "front end". Taking the application and imputing it directly. Even the installation of the terminals, probably the most mechanical and easiest of the major parts of the modernization has been postponed from September 1987 until November 1988. The real problems, however, are yet to come with the "back end" of the modernization dealing with automated benefit adjustments, also called Release III. Recently the functional specifications for Release III were sent for comments to the Regional Commissioners and other user components.

The comments were virtually unanimous in their disappointment:

> The Regional Commissioner from NY said, "Our general reaction to Release III was disappointment because it did not meet our expectations of the system redesign. In most respects, the specifications adequately define a MCS process to replace the current caps/SSaccs capabilities, but these specifications simply duplicate the existing system with most of its

current limitations and inadequacies."

(Attachment II) From the Office of Central Operations, "The field is highly dissatisfied with the level of automation proposed for the MCS, not only with the back-end software replacing CAPS, but also with the front end modernization of the application taking process, as well,."

(Attachment III) One other set of comments provides even more meaningful insight into the modernization:

"The proposed MCS backend needs substantial enhancement before it will meet user needs. We are reluctant to see the backend implemented before these improvements can be incorporated because of our experience with Release I."

Release I was a fast-track effort to bring up a set of title II Direct Access Data Entry claims screens in early 1985. To meet the time deadline, we had to make a number of compromises in the design and capabilities of the system. We were willing to accept these limitations at the time because an improved design was scheduled for implementation a few months later.

We still do not have that new frontend and will not until the of 1986. And correcting piecemeal the problems created by bringing up this prototype frontend has been a difficult task, both for the Office of Systems (OS) and for the users.

We have identified a number of enhancements needed

> before the software will be ready for national implementation. Most of these enhancements were identified by field users in the Model District Office or by the pilot office employees. These suggestions run the gamut from a few minor design problems, that currently cause as high as 17 percent of our claims to be excluded from MCS processing, to a large number of small glitches, that individually are only nuisances but which cumulatively make MCS very complex to learn and use.
>
> In order to make the transition to an automated environment as stress-free for employees as possible, it is important that we make MCS as easy to learn as possible prior to our beginning training for national implementation in the December 1986 to January 1987 time period. However, the Office of Software Improvement and Engineering (OSIE) tells us that they simply cannot accommodate all approved changes in this timeframe because they lack the necessary resources--requirements writers and programmers.
>
> "Yet in spite of being unable to allocate sufficient resources to the task of cleaning up the frontend, OS is pressing to speed up the development of other program benefit areas..."

The documents from which these quotes are taken are attached for your review.

Contract abuse has plagued the modernization from the onset. Perhaps, hopefully, the scandals are over. But now the products of the contractors are coming in, and the products do not appear as the salesman promised. Failed contracts and delays are common place especially concerning the crucial software. GAO has also studied the modernization and a report is due this summer. I'm sure their analysis will contribute to the conclusion that the modernization is not all that it was said to be, and that it doesn't warrant the staffing reductions ordered by OMB and carried out by SSA.

Last year you appropriated 1000 FTE and $30 million over the Presidents Budget. Gramm-Rudman took all of it along with temporary employees, and substantial amounts of money for overtime, travel and training.

Whether or not Gramm-Rudman strikes again, the Agency is continuing to reduce staff according to the OMB staffing reduction plan. Since the modernization is not picking up the slack, other expediencies are being taken to accommodate the cuts which of course, impact on service delivery.

Reducing the assistance claims by district office personnel is one such expediency. Another is Direct Office Final Authorization (DOFA) which will save 1000 FTE. DOFA is being advertised as an efficiency. What it does is simply dump the most complex time consuming cases on the claims rep in the D.O., to be worked without review and finally authorized in the D.O. Error definitions were radically changed and a cooked six-months study of a miniscal sample of cases performed, providing the basis for the SSA to proclaim that DOFA will have only a limited effect on accuracy and save 1000 FTE's.

Although GAO has been quite busy at SSA, the severe impact of DOFA expansion on accuracy warrants another venture by GAO into the justification for DOFA and congressional action to block implementation.

Such expediencies only erode the public confidence in Social Security. To safeguard this important program, to allow the modernization time to develop, to maintain service during this difficult transition period and to break the cycle of indiscriminate staffing cuts we wish the Committee to install a personnel floor at least at the FTE figure of 77,349 agreed to in the 1985 appropriations. Without the personnel floor included in the appropriations bill this year, the confrontation due to staffing cuts, modernization setbacks and decreased service delivery is inevitable. Intent language or additional money and FTE authority simply won't stop the arbitrary reductions being promulgated within SSA.

Finally, the coming of a new commissioner with obvious different philosophies adds another dimension to the current difficulties. The inevitable reorganization and senior level changes that historically accompany a new commissioner again argues for the need to go slow. Please consider our requests to carefully look at the expediencies being taken to accommodate staffing cuts along with the current state of the modernization and their impact on service delivery. Also please provide the personnel floor at 1985 levels to protect Social Security from administrative dismantlement and safeguard this fine program for future generations.

Thank you for the opportunity to deliver our comments to your deliberations.

United States General Accounting Office

GAO

Briefing Report to
Congressional Requesters

March 1986

SOCIAL SECURITY

Actions and Plans to Reduce Agency Staff

GAO/HRD-86-76BR

> waiting times, etc. The Committee therefore directs the Commissioner to develop a report on these measures by January of 1986 and to submit this data to the Committee quarterly for at least the next two fiscal years. In this manner both SSA and the Congress should be able to evaluate the impact of any changes which may be made in staffing, field structure, data processing or telecommunications."

As of March 10, 1986, SSA had not delivered a report to the Subcommittee.

WHAT ARE SSA'S PLANS FOR FUTURE REDUCTIONS?

SSA has not updated its plan to achieve its goal of a 17,006-FTE reduction through fiscal year 1990. Nonetheless, the agency expects to realize substantial staff savings from the initiatives outlined in its original plan. The following sections describe these initiatives, what SSA currently expects to save and when, and what the agency is doing to realize the savings.

Overall, SSA's projections of savings from these initiatives are largely tentative, according to agency officials. Further, in many cases, it appears to us they may not produce the savings when or to the extent originally anticipated.

The Claims Modernization Project

The CMP accounts for 5,325 of the 17,006 FTE savings projected in the long-range staff reduction plan. The CMP is part of SSA's Systems Modernization Plan, a strategic effort begun in 1982 to bring SSA's computer operations up to state-of-the-art.

SSA expects that the CMP will reduce staff requirements by

--permitting direct input of claims application data by field office claims representatives,

--giving claims representatives immediate access to earnings and account number verification data,

--increasing the number of claimant notices that can be generated automatically, and

--automating workload management so that case actions are tracked automatically.

SSA also expects the CMP to reduce staff requirements by reducing claims processing errors.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to SD2B2

Memorandum

SY-20

Date February 11, 1986

From Regional Commissioner
New York

Subject Field Review of Release III -- INFORMATION

To Acting Director
Field Liaison and Support Staff

The functional specifications for the Modernized Claims System (MCS) Release III were reviewed by representatives from regional and field office staffs in the Atlanta, Chicago, and New York Regions. Our comments are based on the feedback from these workgroups and from the Field Liaison and Support Staff.

The 1986 ADP Plan describes the Title II Claims Modernization Project as follows:

> "This project involves a complete software redesign of those ADP operations which support the title II claims process. The redesign is intended to provide users with baseline documentation of the claims process, real-time data entry and validation capabilities and effective transaction control capability as well as standardized and highly automated computation, beneficiary notice generation and standardized free-form output capabilities. This project includes the CAPS claims improvements recommended by users. Implementation will occur in three phases."

This best describes the type of system that is needed by the field.

Our general reaction to Release III was disappointment because it did not meet our expectations of the system redesign. In most respects, the specifications adequately define a MCS process to replace the current CAPS/SSACCS capabilities, but these specifications simply duplicate the existing system with most of its current limitations and inadequacies. Although Release III eliminates CC (CAPS) batch traffic for MCS claims, and does provide more on-line processes, front and back-end concepts continue to exist. We are concerned that these limitations may constrain future upgrades. We question whether Release III, as currently defined, can be the foundation for a true on-line, interactive, and real-time system.

It was difficult to fully and accurately assess Release III because we as users do not have experience in reviewing functional specifications. The specifications did not contain much documentation about how the MCS system is going to operate, interact/interface or process data. The reviewers often had to refer to the CMP handbook and POMS to interpret many sections in the 23 volumes. Consequently, we believe that programmers may have trouble making the proper coding decisions unless additional background and procedural material are provided.

Furthermore, the Office of Systems needs to recognize that users' feedback is a dynamic process. Provision should be made to obtain and respond to additional users' concerns as the project progresses. (Provision should especially be made to allow the Regional Security Officers to make additional comments after they receive FOSE training in February.)

Our comments on the 23 volumes are contained in the attached material. In this memorandum, we have highlighted some of the major issues which we believe should be addressed.

MCS Operations

We did not find the data input screens for Release III to be user-friendly. For the most part, the CAPS methods of treating data are retained. As such, the screens still require extensive coding, similar to the data entry needed for form SSA-3687 (CAPS Clearance Form). Instead of coding, questions should be in English and the data should be derived by the system. Interviewers should be able to enter information, with the aid of programmed prompts, as it is logically obtained from the claimant. Furthermore, interviewers need the ability to move directly to any specified screen. Release III, as planned, will not help the field to reduce its leading sources of basic dollar and evidentiary errors.

This system encompasses over 70 interviewing, development, adjudication, clearance, and review screens. Response time for these screens will directly affect waiting, interviewing, and processing times. We are also concerned that if the entire MCS data base is housed in Baltimore, systems outages could severely hinder the field's operations. Finally, since the MCS must shut down every night to update the MBR, provision needs to be made that there is no interruption of service during normal working hours to SSA offices on the West Coast and Hawaii.

MCS should be designed to perform on-line, interactive, and eventually real-time processing of data. It should also perform automatic adjudicative interfaces, and on-line computations. We suggest that the title XVI system be studied for this purpose. The title XVI system is integrated and does not have a front or back-end. The SSR is established based on field input and an on-line query can be obtained prior to payment or denial to determine what data has been entered into the system. This capability should exist in some format for title II.

Computations

The specifications, as written, do not provide for on-line, automated computations. This facility is extremely valuable to the field. Although some of the CAPS limitations will be processed through MCS, others have been omitted for no apparent reason. For example, we do not understand why the system cannot be programmed to send the first check to an authorized representative, to split the lump sum among three claimants, or to withhold a prior overpayment from the first check. In Volume 11, we have expanded on other manualized and non-manualized CAPS exclusions which we believe should be automated in Release III.

Interfaces - OCRO and DDS'

The specifications for obtaining earnings information are still being formulated and were not included in the 23 volumes. Based on the other features of MCS, Release III does not seem to incorporate the use of an on-line earnings reference file (ERF). Earnings-related issues are often complex and time-consuming. The field has anxiously been awaiting the nationwide implementation of the on-line ERF query, which is now being piloted in Atlanta and Chicago. On-line earnings capabilities need to be integrated into the claims process.

Although the DDS', like other Paradyne equipped installations, will receive new terminals and be connected to the Data Communications Utility (DCU), no direct MCS access is provided for them. Instead, a convoluted interface through the SSI system is defined, using title II data derived from unchanged SSA-4648 input procedures. Interaction between field offices and DDS' should be fully automated in Release III.

Notices

In April 1985, all regions provided comments on the contents of the initial claims notices for CMP. These comments, which pertain to Volumes 19 and 20, are still applicable.

We are concerned about the notice issuance process, because Release III does not seem to be an enhancement. In certain situations, the field will still have to manually enter requested paragraphs, which because of the Notice Improvement Project have been converted to five digit numeric codes. Final notices will still be produced in an overnight batch mode upon claims completion. To aid the adjudicators in learning and coding proper paragraphs under MCS III, we have recommended the development of a "Help" screen.

Additionally, the field needs the capability to input free-format dictated language that can be incorporated by the system into the standard notice. This is particularly important in light of the recent decision to expand DOFA to all claims. Otherwise, the PSCs will still have to manually type notices when a special paragraph is needed.

Workload Measurement System (WMS)

In June 1985, the regions commented on the WMS for Release III. Those comments, as well as some additional ones that we discussed in Volume 18, need to be incorporated into the functional specifications. Furthermore, field office managers and regional office personnel in all regions completed an extensive survey last summer concerning management information requirements as part of the Management Information for Decisionmaking Project (MID). The specifications developed as part of the MID project should also be used in constructing the data specifications for MCS-FOSE.

Release III Implementation

We believe that the segmented, (i.e., certain retirement claims only) approach to implementation would have an adverse effect on all aspects of field operations. Release III is itself part of a planned phase-in of MCS. As such, in May 1987, some of our field offices will be operating with Release II software (already processing a full range of title II claims through MCS), others will be in the process of DCU and terminal installation, or in various stages of advance training and preparation for FOSE. Phasing in of Release III will create a need for additional training, development of specialized workflows, and multiple types of quality and security reviews.

We also do not see the advantage of converting only the "clean" retirement claims to MCS processing. If it is necessary to validate Release III, it should be done in designated pilot offices.

In our opinion, Release III contains inherent management information problems because MADCAP and other systems limitations which are not eliminated will be controlled by SSACCS. MCS claims will be controlled by the WMS. The specifications do not address how data for claims processed via existing payment processes and presently recorded on SSACCS will be combined with or incorporated into data produced by WMS. Unless an interface between MCS and WMS is established, statistics will be inconsistent, unreliable and often invalid. A phased-in implementation would make these management information conditions even more unacceptable, because all offices would have three methods of processing claims - MCS, CAPS, manual-MADCAP/EAM.

The optimal claims process requires a fully automated systems environment. Based upon our review of the functional specifications, Release III, as presently proposed, will not appreciably assist us in achieving this objective. Our comments address various concerns with Release III and are intended to make the system more responsive to the field's needs. We believe these concerns need to be considered before progressing further with the project.

In summary, we recognize the substantial amount of work and effort that is being made to institute a modernized claims system for SSA. However, we are concerned with what appears to us to be a fragmented approach to the various CMP endeavors. There are several projects (i.e., Release III Specifications, Program Benefits Lag Functional Requirements, Release II software changes, and other PE/MBR enhancements) that are running concurrently and have overlapping functions. We think that greater coordination of these activities could result in SSA's achieving a fully automated system in a more efficient, effective, and timely manner.

If your staff needs additional information or clarification about our review, please call Anne Coe of the Systems Branch at FTS-264-0253.

Peter P. DiSturco

Attachment

AS-7-10

FEB 20 1986

SPN-6

TO : Ruth A. Pierce

SUBJECT: OCO Comments on Functional Specification for Release 3 of the Modernized Claims System (MCS)--ACTION

Attached for your signature is a covering memorandum to Janice Warden transmitting OCO comments on the functional specifications for the release 3 software of the MCS. An advance copy of the comments was hand-carried to the Field Liaison and Support Staff (FLSS) so that they could prepare a covering memorandum from Herbert Doggette to Arthur Simermeyer in time to respond to Systems early next week. All of the copies will be printed for distribution after you sign the covering memorandum.

You might be interested in a copy of the covering memorandum transmitting the regional comments. The field is highly dissatisfied with the level of automation proposed for the MCS, not only with the back-end software replacing the Claims Automated Processing System, but also with the front-end modernization of the application taking process, as well. Because the MCS to date falls short of the modernization promised, FLSS is preparing a note to Herbert Doggette which proposes that he request Systems to concentrate on refining the front-end and making the back-end system more truly interactive and online before devoting resources to modernize other areas such as the supplemental security income and the postentitlement processes.

The first thing that needs to be done is to forward the attached comments. I would like to meet with you as soon as your schedule permits to discuss a strategy for pursuing further modernization initiatives.

George Failla

Attachments:
Tab A - Regional Commissioner, New York Memo, 2/11/86
Tab B - Memo for Your Signature to Janice Warden

SAY

FEB 26 1985

TO : Mr. Herbert R. Doggette, Jr.

SUBJECT: Operations' Comments on the Claims Modernization Project/Field Office Systems Enhancement Release III Functional Specifications—INFORMATION

During the last 2 months, Operations' staff have been reviewing the 23 volumes of Release III functional specifications for the backend of the title II Modernized Claims System (MCS). The field review was headed by the New York Region, with Atlanta, Chicago, and the Field Liaison and Support Staff participating. Field comments are located at tab A.

The Office of Central Operations (OCO) also distributed the functional specifications to the processing centers and the Office of Central Records Operations for review. Their consolidated comments are located at tab B.

Our review has pinpointed a number of areas where Release III falls short of the kind of modernized system that we have been expecting. The regions and OCO have both expressed disappointment with the failure of Release III to significantly improve on the current Claims Automated Processing System (CAPS). We were aware that automation of Manual Adjustment, Credit and Award Processes (MADCAP) claims would not be available in the initial MCS backend. However, we did expect Release III to improve on a number of other CAPS limitations and inadequacies. *

First of all, MCS should improve on the CAPS data input method. CAPS was designed in an era when claims representatives (CR's) took applications on paper. Data review technicians then converted this information into coding for keying into the computer. Now that the CR is entering the entire application into the computer, very little coding should be required. However, the Release III requirements fall short of accomplishing this goal.

From our review, it also appears that MCS fails to take full advantage of our new online data bases. MCS should directly interface with the Master Beneficiary Record, the Summary Earnings Record, and the Supplemental Security Record to derive data, such as prior periods of disability and cross-reference indicators, rather than have the user key in this information. *The specifications do not include these interfaces.

In other areas, we were unable to determine whether the new process will meet our needs because information we needed to make an assessment was not included in the specifications. The biggest example of this is the earnings record interface. Without information on this process and additional information on the application-eligibility/entitlement interface, it is difficult to judge whether the full MCS will provide the kind of online, interactive claims system we have been expecting.

The proposed MCS backend needs substantial enhancement before it will meet user needs. We are reluctant to see the backend implemented before these improvements can be incorporated because of our experience with Release I.

Release I was a fast-track effort to bring up a set of title II Direct Access Data Entry claims screens in early 1985. To meet the time deadline, we had to make a number of compromises in the design and capabilities of the system. We were willing to accept these limitations at the time because an improved design was scheduled for implementation a few months later.

We still do not have that new frontend and will not until the end of 1986. And correcting piecemeal the problems created by bringing up this prototype frontend has been a difficult task, both for the Office of Systems (OS) and for the users.

We have identified a number of enhancements needed before the software will be ready for national implementation. Most of these enhancements were identified by field users in the Model District Office or by the pilot office employees. These suggestions run the gamut from a few minor design problems, that currently cause as high as 17 percent of our claims to be excluded from MCS processing, to a large number of small glitches, that individually are only nuisances but which cumulatively make MCS very complex to learn and use.

In order to make the transition to an automated environment as stress-free for employees as possible, it is important that we make MCS as easy to learn as possible prior to our beginning training for national implementation in the December 1986 to January 1987 time period. However, the Office of Software Improvement and Engineering (OSIE) tells us that they simply cannot accommodate all approved changes in this timeframe because they lack the necessary resources—requirements writers and programmers.

Yet in spite of being unable to allocate sufficient resources to the task of cleaning up the frontend, OS is pressing to speed up the development of other program benefit areas. A Systems group has already developed a set of preliminary Supplemental Security Income (SSI) application screens and, based on the limited information we have, hopes to have these ready for piloting in mid-1987. Systems has also suggested that they plan to take on development of the title II postentitlement (PE) frontend screens soon.

Meanwhile, another Systems component has just begun the task of developing functional requirements for these and the other program benefit LAG's. A team of contractors only recently began making yet another series of visits to the field to survey user needs before writing these requirements, due by the end of 1986.

To those of us outside of OS, all of this varied activity going on in different directions and at different paces is highly confusing. We are extremely skeptical that working on SSI claims and title II PE will not detract from our ability to deliver a quality title II claims system.

Given SSA's limited resources, we cannot afford to expend resources in counterproductive ways. Before proceeding further down these many paths, we need to step back and determine what the Agency's needs are and which modernization efforts will have the biggest payoff towards meeting those needs.

In our assessment, the first task should be to clean up the title II claims frontend before we begin training for national implementation. This will mean providing sufficient requirements writers and programmers to implement corrections and enhancements already submitted to OSIE and to respond to the feedback we gain from our Phase II pilot employees.

Secondly, we need to make certain that the design of the new title II backend provides a truly modernized claims system before we begin implementing it. If this requires delaying implementation of Release III to provide Systems with the time they need to modify and expand the specifications, then we must do so.

Thirdly, before SSA commits resources to other program benefit enhancements, we need to take a good look at where the biggest payoff is in providing systems support to our employees performing programs tasks. When the Operations Strategic Planning team looked at our needs, they determined that the title II PE backend should be this task. The title II backend is an enormous undertaking and certainly does not have the quick results for show that a much simpler task, such as the SSI claims frontend, has. But our decision on what to do next must be based on Agency needs, not ease of the task.

Beyond title II PE, focusing on the resource-intensive SSI redetermination process may also have a bigger payoff than building SSI initial claims screens.

Given the impact of program benefits modernization on Operations activities, we need substantial input into the decision of what tasks Systems should devote its resources to. Our goal should be to deliver a quality, truly modernized system to our employees. Incorporation of these comments into the title II claims backend before proceeding with its implementation will be a major step towards achieving systems modernization.

Janice L. Warden

Attachments:
Tab A - Field Comments
Tab B - OCD Comments

WEDNESDAY, MAY 7, 1986.

HCFA

WITNESS

DR. MAURICE MAHONEY, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Mr. NATCHER. Our next witnesses is Dr. Maurice Mahoney.

Come around, Dr. Mahoney. We will be pleased to hear from you at this time.

Dr. MAHONEY. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Dr. Maurice Mahoney. I am a pediatrician and professor at Yale University School of Medicine in New Haven, Connecticut.

Thank you for the opportunity to express my views and those of the March of Dimes Birth Defects Foundation on the importance of preventive health care initiatives to the lives and health of our nation's children.

I have joined with the March of Dimes for many of its educational efforts, both at national conferences and in local communities, and have served on its advisory boards. I have been professionally concerned with child health issues for 25 years.

The March of Dimes appreciates your concerns regarding the need to reduce the Federal deficit, and understands the impetus for planned cuts to meet these ends.

In an era of budgetary restraints, society must scrutinize spending programs carefully—investing in those that protect our nation's health and those that will, in the long run, save taxpayers' money.

In the area of preventive health care, the priorities are clear: Medical research and preventive health care programs save lives and money. It is imperative for the Federal Government to provide continued adequate funding for childhood immunizations, medical research, and quality prenatal care. Failure to do so will cost much money and many lives.

First let me examine the cost effectiveness of childhood immunizations. Today more than 95 percent of school-aged children are vaccinated against the preventable diseases of childhood. Funding for the immunization program through the Centers for Disease Control (CDC) provides grants to states to conduct immunization activities and to purchase vaccines for use in public clinics.

In its 20 years, this program has dramatically reduced the incidence of all the infectious diseases against which it has been targeted.

The savings in suffering and anguish, and the value of a generation spared from fear of crippling or fatal infection, are incalculable. But we can quantify the monetary savings.

By vaccinating our children against polio, the U.S. avoids $1,000,000,000 annually in economic losses, according to the CDC division of immunization. That means that this year our society saved $10 for every dollar it invested in the program.

Since 1963, a vaccine against measles and rubella was ready for use. According to a CDC surveillance report, more than 59 million cases of measles have been prevented since 1963. More than 19,500 children have been spared congenital rubella syndrome—exposure to rubella in the womb and a life spent mentally retarded, deaf, blind, or all three. The lives of more than 5,900 children have been saved.

Using measles and rubella vaccine, the U.S. saves $500,000,000 per year. This is a cost-effectiveness ratio of $14 saved for every dollar spent.

Unfortunately, as we review these impressive figures, the financial and human savings from the childhood immunization program are in jeopardy.

In the budget for fiscal year 1987, the administration has proposed $56,000,000 in funding, a decrease of $3,600,000 from the level approved in fiscal year 1986.

In addition, the program has lost $2,600,000 as a result of the fiscal year 1986 Gramm-Rudman-Hollings automatic cuts. These cuts already force states to make life-and-death decisions about vaccines.

The childhood immunization program has been a major accomplishment in public health.

We urge you to advocate an increased appropriation that takes into account the rise of vaccine prices and we urge you to support a six-month stockpile of vaccine.

Recent public health accomplishments, like protecting our children from infectious disease through immunization, would never have been possible without years of basic medical research. Without laboratory studies of viruses, there would be no vaccines. Without clinical research studies, laboratory successes would not be converted into healthier children.

The March of Dimes is concerned that a lack of funds for National Institutes of Health (NIH) medical research will stall progress in combatting birth defects, our nation's single largest child health problem.

Birth defects include an abnormality in a body's structure or its ability to function, whether genetically determined or as a result of environmental influence during embryonic or fetal life. Birth defects also include the problem of children born too small or too soon, who weigh less than 5½ pounds.

Two-thirds of all infant deaths occur among LBW babies. Among survivors, the incidence of handicap is high. Low birth-weight children may suffer from slow mental and physical development, respiratory, heart, kidney, or nervous system disorders.

The prevention of birth defects is a staggeringly complex task. Solving more than 3,000 known birth defects will require pioneering research in many disciplines and coordinated public health efforts.

In this effort, it is crucial to adequately support the research programs of the National Institute of Child Health and Human Development (NICHD).

The proposed budget also will adversely affect NICHD programs to prevent low birth-weight and infant mortality, our nation's most devastating child health failure. The United States' international ranking in infant mortality—eighteenth in the world—is a tragic betrayal of our commitment to the health of our people. Nearly 11 out of every 1,000 infants born in this country never live to see their first birthday.

To improve this dismal record, NICHD in 1984 began an expanded research program to prevent low birth-weight.

Budget cuts already have undermined the program. In the 1986 Gramm-Rudman-Hollings cuts, $236,000,000 was slashed from NIH, $14,900,000 from the NICHD. Of ten proposed maternal and fetal care research units, only seven will become operational. Of ten proposed neonatal intensive care research units, again, only seven will become operational.

Private organizations cannot make up for these cuts. As an indication of the impact, the money lost from NICHD in the 1986 Gramm-Rudman-Hollings cuts is greater than the entire annual research budget of the March of Dimes.

We recommend that NIH be funded at a level to support 6,100 grants, the number set by Congress in last year's reauthorization bill. We strongly support sufficient funding for NICHD and its many vital programs, including the perinatal emphasis research centers, and we urge at least a 15 percent increase in funding of NIH.

Medical research has documented the effectiveness of one strategy to prevent infant death. After analyzing numerous studies, the Institute of Medicine, a part of the National Academy of Sciences, concluded that the prevention of low birth-weight could significantly reduce infant mortality in the United States and, more generally, improve child health. We agree.

Early and regular prenatal care reduces the incidence of low birth-weight, neonatal death, and other complications of pregnancy. Unfortunately, in 1983, 5 percent of all white mothers and 10 percent of all black mothers in this country received delayed or no prenatal care.

If society adequately funds prenatal care, we will not have to wait even one year to reap the medical and financial benefits. A recent California study compared the medical complications and initial hospitalization costs between high-risk women who received prenatal care and those who did not. The "no care" patients were more likely to have uncontrolled hypertension, give birth prematurely, and deliver newborns in poor medical condition or who had already died.

The study also showed that prenatal care saves money. After paying for all prenatal care costs, and the mothers' and infants' hospital bills, there was a net savings of approximately $2,000 per delivery by providing prenatal care. That is amazingly cost effective.

A congressional staff report estimates that, nationwide, the Federal Government could save more than $361,000,000 per year simply by providing comprehensive prenatal care to all low-income women.

This does not include the savings in infants' lives. And it does not include the long-term savings in costs of caring for low-birth-weight infants who survive.

Prenatal care visits cost about $600 per patient. Life-long institutional care for a developmentally disabled child costs between $400,000 and $1,000,000.

We support the $100,000,000 Medicaid program to combat infant mortality, which is part of the Senate Budget Committee's resolution.

We recommend full funding for prenatal care programs, including the funding of Medicaid and Maternal Child Health block grants at the fully authorized levels.

In summary, I believe that cuts in preventive health programs—childhood immunization, medical research, and prenatal care—are medically and socially irresponsible. Worse, they are economic mistakes.

I am not just talking about the lives and health of our children, and I am not just talking about the long-term investment, the dollars that ensure the next generation will become healthy, productive citizens. I am talking about savings for this year—savings that we have the power to realize in fiscal year 1987 with preventive health care measures.

Thank you.

Mr. NATCHER. Thank you, Dr. Mahoney. You have given us an excellent statement.

[The statement of Dr. Mahoney follows:]

STATEMENT OF

MAURICE MAHONEY, M.D.
PROFESSOR OF PEDIATRICS, OBSTETRICS AND GYNECOLOGY
YALE UNIVERSITY SCHOOL OF MEDICINE

AND RECIPIENT OF
MARCH OF DIMES BASIL O'CONNOR STARTER RESEARCH AWARD

ON BEHALF OF THE

MARCH OF DIMES BIRTH DEFECTS FOUNDATION

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION
AND RELATED AGENCIES

May 7, 1986
3:00 PM

Mr. Chairman and members of the committee, I am Dr. Maurice Mahoney. I am professor of genetics, pediatrics, and obstetrics and gynecology at Yale University School of Medicine in New Haven, Connecticut.

Thank you for the opportunity to express my views, and those of the March of Dimes Birth Defects Foundation, on the importance of preventive health care initiatives to the lives and health of our nation's children. The March of Dimes has been dedicated to the prevention of birth defects for more than a quarter-century through its programs of research, education, and medical services.

I have joined with the March of Dimes for many of its educational efforts, both at national conferences and in local communities, and have served on its advisory boards. I have been professionally concerned with child health issues for 25 years, and my entire career in academic medicine has been devoted to understanding the causes of disease in childhood and developing means of prevention.

The March of Dimes appreciates your concerns regarding the need to reduce the federal deficit, and understands the impetus for planned cuts to avoid the automatic sequestration provision of the Gramm-Rudman-Hollings balanced-budget law. In an era of budgetary restraints, society must scrutinize spending programs carefully -- investing in those that protect our nation's health and those that will, in the long run, save taxpayers money. In the area of preventive health care, the priorities are clear.

Medical research and preventive health care programs save lives and money. It is imperative for the federal government to provide continued adequate funding for childhood immunizations, medical research, and quality prenatal care. Failure to do so will cost much money and many lives.

CHILDHOOD IMMUNIZATIONS

First let's examine the cost effectiveness of childhood immunizations. Today, more than 95 percent of school-aged children are vaccinated against the preventable diseases of childhood. Funding of the immunization program through the Centers for Disease Control (CDC) provides grants to states to plan, organize, and conduct immunization activities and to purchase vaccines for use in public clinics.

In its 20 years, this program has dramatically reduced the incidence of all the infectious diseases against which it has been targeted.

The savings in suffering and anguish, and the value of a generation spared from fear of crippling or fatal infection, are incalculable. But we can quantify the monetary savings.

By vaccinating our children against polio, the U.S. avoids $1 billion annually in economic losses, according to the CDC division of immunization. That means that this year our society saved $10 for every dollar it invested in the program.

In the 1960s, a vaccine against measles and rubella was ready for use. According to a CDC surveillance report, more than

59 million cases of measles have been prevented since 1963. More than 19,500 children have been spared congenital rubella syndrome -- exposure to rubella in the womb and a life spent mentally retarded, deaf, blind, or all three. The lives of more than 5,900 children have been saved.

Using measles and rubella vaccine, the U.S. saves $500 million per year. This is a cost-effectiveness ratio of $14 saved for every dollar spent.

Unfortunately, as we review these impressive figures, the financial and human savings from the childhood immunization program are in jeopardy. In the budget for fiscal year 1987, the administration has proposed $56 million in funding, a decrease of $3.6 million from the level approved in fiscal year 1986. In addition, the program has lost $2.6 million as a result of the fiscal year 1986 Gramm-Rudman-Hollings automatic cuts. These cuts already force states to make life and death decisions about vaccines.

It is estimated that 65,000 children will be inadequately immunized because of these automatic cuts. If the 1987 budget proposal is accepted, 400,000 children will be unprotected.

The 1987 budget proposes no funds to stockpile reserves of vaccines, and the vaccine supply is precarious. There is only one manufacturer of polio and measles, mumps, and rubella vaccine in this country. If, for any reason, production were suspended, our vaccine would be depleted in three months.

The childhood immunization program has been a major accomplishment in public health. Do not cripple this money- and life-saving program. Do not forfeit more than $1 billion a year, and rob our children of an important benefit of living in a 20th century, developed nation.

We urge you to advocate an increased appropriation that takes into account the rise of vaccine prices and we urge you to support a six-month stockpile of vaccine.

MEDICAL RESEARCH

Recent public health accomplishments, like protecting our children from infectious disease through immunization, would never have been possible without years of basic medical research. Without laboratory studies of viruses, there would be no vaccines. Without clinical research studies, laboratory successes would not be converted into healthier children.

The March of Dimes is concerned that a lack of funds for National Institutes of Health (NIH) medical research will stall progress in combatting birth defects, our nation's single largest child health problem. Birth defects include an abnormality in a body's structure or its ability to function, whether genetically determined or as a result of environmental influence during embryonic or fetal life. Birth defects also include the problems of children born too small or too soon, who weigh less than 5 1/2 pounds and are 40 times more likely to die than fully developed newborns. Seven percent of infants born in this country are of low birthweight (LBW) -- 250,000 of these babies are born every year. Two-thirds of all infant deaths occur among LBW babies. Among survivors, the incidence of handicap is high. Low birthweight children may suffer from slow mental and physical development, respiratory, heart, kidney, or nervous system disorders.

The prevention of birth defects is a staggeringly complex task. Solving more than 3,000 known birth defects will require pioneering research in many disciplines and coordinated public health efforts. In this effort, it is crucial to adequately support the research programs of the National Institute of Child Health and Human Development (NICHD). Research into genetic diseases, an area with which I am deeply involved, today is at a critical point. Many of us who work with the March of Dimes spend our lives treating the impact of genetic disease, performing surgery to alter structural problems such as heart or limb defects, devising medications or special diets to prevent progressive damage from a missing body chemical, and counseling families who must watch their children die.

We are nearing the day when researchers attempt to cure genetic disease at the source -- turning on an inactive gene or inserting a normal one that can take over for a mistake in the hereditary blueprint.

The first step toward gene therapy has already been taken for many disorders -- finding the exact location of the faulty gene on the chromosome.

Besides numerous research grants, NICHD recently established a repository where copies of human genes will be stored for researchers. Unfortunately, while an NIH committee is ready to receive applications for the first human gene therapy trials, the 1987 Fiscal Year budget will decrease grants in this area.

The proposed budget also will adversely affect NICHD programs to prevent low birthweight and infant mortality, our nation's most devastating child health failure. The United States' international ranking in infant mortality -- eighteenth in the world -- is a tragic betrayal of our commitment to the health of our people. Nearly 11 of every 1,000 infants born in this country never live to see their first birthday.

To improve this dismal record, NICHD in 1984 began an expanded research program to prevent low birthweight.

Budget cuts already have undermined the program. In the 1986 Gramm-Rudman-Hollings cuts, $236 million was slashed from NIH, $14.9 million from the NICHD. Of 10 proposed maternal and fetal care research units, only seven will become operational. Of ten proposed neonatal intensive care research units, again, only seven will become operational.

Private organizations cannot make up for these cuts. As an indication of the impact, the money lost from NICHD in the 1986 Gramm-Rudman-Hollings cuts is greater than the entire annual research budget of the March of Dimes.

We recommend that NIH be funded at a level to support 6,100 grants, the number set by Congress in last year's reauthorization bill. We strongly support sufficient funding for NICHD and its many vital programs, including the perinatal emphasis research centers, and we therefore urge at least a 15% percent increase in funding of NIH. In the area of research to improve the health of our children, the private sector cannot prevent the damage that budget cuts would inflict.

PRENATAL CARE

Medical research has documented the effectiveness of one strategy to prevent infant death. After analyzing numerous studies, the Institute of Medicine, a part of the National Academy of Sciences, concluded that the prevention of low birthweight could significantly reduce infant mortality in the United States and, more generally, improve child health.

The Institute of Medicine (IOM) reports that "the overwhelming weight of the evidence is that prenatal care reduces low birthweight. This finding is strong enough to support a broad national commitment to ensuring that all pregnant women, especially those at medical or socioeconomic risk, receive high-quality care."

The March of Dimes, which partially funded the IOM study, agrees with this finding. Quality prenatal care visits are vital to detect and promptly treat high-risk medical and obstetrical complications, such as preterm labor and maternal infections. Quality prenatal care visits also make possible the introduction and reinforcement of educational messages that will guide women in protecting their health and that of their developing babies.

Early and regular prenatal care reduces the incidence of low birthweight, neonatal death, and other complications of pregnancy. Unfortunately, in 1983, five percent of all white mothers and 10 percent of all black mothers in this country received delayed or no prenatal care.

If society adequately funds prenatal care, we will not have to wait even one year to reap the medical and financial benefits. A recent California study compared the medical complications and initial hospitalization costs between high-risk women who received prenatal care and those who did not. The "no care" patients were more likely to have uncontrolled hypertension, give birth prematurely, and deliver newborns in poor medical condition or already dead.

The study also showed that prenatal care saves money. After paying for all prenatal care costs, and the mothers' and infants' hospital bills, there was a net savings of $2,194 per delivery by providing prenatal care. That is amazingly cost effective. A congressional staff report estimates that, nationwide, the federal government could save more than $361 million per year simply by providing comprehensive prenatal care to all low-income women.

This does not include the savings in infants' lives. And it does not include the long-term savings in costs of caring for low-birthweight infants who survive. Prenatal care visits cost about $600 per patient. Life-long institutional care for a developmentally disabled child costs between $300 thousand and $1 million.

We support the $100-million Medicaid program to combat infant mortality, which is part of the Senate Budget Committee's resolution. We recommend full funding for prenatal care programs, including the funding of Medicaid and Maternal Child Health block grants at the fully authorized levels.

In summary, I believe that cuts in preventive health programs -- childhood immunization, medical research, and prenatal care -- are medically and socially irresponsible. Worse, they are economic mistakes. I'm not just talking about the lives and health of our children. And I'm not just talking about the long-term investment, the dollars that ensure the next generation will become healthy, productive citizens. I'm talking about savings for this year -- savings that we have the power to realize in Fiscal Year 1987.

WEDNESDAY, MAY 7, 1986.

DEVELOPMENTAL DISABILITIES, NICHD

WITNESSES

WILLIAM E. JONES, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS

DR. HUGO W. MOSER, PRESIDENT, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS

TERRENCE R. DOLAN

ANDY SEGAL

Mr. NATCHER. Our next group of witnesses are Dr. Jones, Dr. Moser and Dr. Dolan and Mr. Segal.

Who will be the spokesman?

Dr. MOSER. I am Hugo Moser, and I will speak for four and a half minutes.

Mr. NATCHER. Well, good, go right ahead.

Dr. MOSER. I am Director of the Kennedy Institute for Handicapped Children in Baltimore, and represent 43 of the university-affiliated programs for people with developmental disabilities.

Dr. Terry Dolan represents the 12 Mental Retardation Centers in the United States. Our testimony will be presented by Mr. Andy Segal, who I am very proud to introduce.

Mr. Segal is a graduate of Harvard College. He has spent a year as a trainee at the Kennedy Institute, and we are proud to say that he will be admitted to the Medical School at Boston University this September.

Mr. Segal will present our testimony.

Mr. NATCHER. Mr. Segal, we are delighted to have you before the committee, and we will be pleased to hear from you.

Mr. SEGAL. It is a great pleasure to be here.

The past two decades have been a significant shift in values. This has been evidenced by commitments to preserve and improve the quality of life for disabled people.

Congress, at the forefront of this movement, created University Affiliated Facilities, UAFs, and Mental Retardation Research Centers, MRRCs, which are charged with charting the course, preparing the leaders, and building capacities.

In addition, the MRRCs are involved in research aimed at understanding development and improving diagnosis and treatment of abnormal development.

To fully appreciate the revolutionary nature of these activities, they must be taken in their historical context. Prior to the 1960s, disabled people were widely regarded as devoid of social or economic value.

They were segregated from society at large, and programs to aid them provided mere life-sustaining "care" rather than "service" that would lead to economic productivity or higher quality of life.

We now wish to highlight just a few of our accomplishments: For example, severely disabled persons are now in public school programs and entering the work force as productive employees, rather than being relegated to institutions. Research achievements include developing interventions to prevent mental retardation from a few of its causes.

I am here to say our successes have created new challenges and opportunities for a healthy, adult and aging population. We must begin to serve disabled people throughout their life cycle.

The AAUAP supports the appropriations recommended by the Consortium for Citizens with Developmental Disabilities. They are conservative and realistic.

If I might, Mr. Chairman, I would like to add that this year, I have been particularly impressed at the work that is done at these facilities. I was quite skeptical that many of these people could be taught to help themselves; that they are, just as I have been.

We thank you.

Mr. NATCHER. Mr. Segal. Thank you very much. You have given us an excellent statement, and I want you to know that we appreciate your attendance at this time.

Mr. Segal, we say to our outside witnesses, we are delighted to have all of you. We hear the Department witnesses for the Department of Labor, the Department of Health and Human Services and the Department of Education.

We listen to them carefully, and we very much concerned about what our outside witnesses say to us. A lot of them travel thousands of miles to get here, and we need all the help we can get on this bill.

This is one of the most, if not the most, important appropriations bills that we have. You have made an excellent statement. We appreciate your appearance before the committee.

I want to wish you the best of everything in the future.

Mr. SEGAL. I appreciate that.

Mr. NATCHER. Gentlemen, thank you very much, we appreciate it.

[The statement follows:]

TESTIMONY

Presented to:

United States House of Representatives
Committee on Appropriations,
Subcommittee on Labor, Health and Human Services,
Education, and Related Agencies

Honorable, William H. Natcher, Chairman

1987 APPROPRIATIONS FOR UNIVERSITY AFFILIATED FACILITIES AUTHORIZED AND FUNDED UNDER THE DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT AND THE SETASIDE PROVISIONS OF THE MATERNAL AND CHILD HEALTH BLOCK GRANT

Respectfully Submitted by:

Hugo W. Moser, M.D., President
American Association of University Affiliated Programs and
Director, The Kennedy Institute for Handicapped Children
Baltimore, Maryland

Terrence R. Dolan, Ph.D., Chairman
Mental Retardation Research Center Consortium and
Director, Waisman Center
University of Wisconsin

and

Andrew Segal, AB Cum Laude, Harvard University
Trainee, The Kennedy Institute for Handicapped Children
Baltimore, Maryland

Representing the American Association of University Affiliated
Programs for Developmentally Disabled Persons and
the Mental Retardation Research Center Consortium

Mr. Chairman and Members of the Committee:

I am Dr. Hugo Moser, President of the Kennedy Institute for Handicapped Children in Baltimore, an affiliate of the Johns Hopkins University, and I am this year's president of the American Association of University Affiliated Programs for Persons with Developmental Disabilities (AAUAP). Joining me is Dr. Terrence Dolan, Director of the Waisman Center University Affiliated Facility and Mental Retardation Research Center located at the University of Wisconsin in Madison. He currently serves as Chairman of the Mental Retardation Research Center Consortium. It is also my privilege to introduce Mr. Andrew Segal, who during the last 9 months has been a trainee at the Kennedy Institute. Mr. Segal is a graduate of Harvard University and has been accepted to three medical schools: Pittsburgh, Boston University and New York Medical College.

The past two decades have seen a significant shift in values. This has been evidenced by a commitment to preserve and improve the quality of life, to initiate research programs aimed at understanding developmental disabilities, and policy and legislation which led to the creation of several programs in response to the needs of persons with developmental disabilities. It was the Congress that was at the forefront of these changes, and new knowledge, technology, services, functions, and expectations had to be developed along with changing the thinking and behavior of an old service system.

To implement this policy, the Congress created University Affiliated Facilities (UAFs) and Mental Retardation Research Centers (MRRCs) charged with the responsibility to chart the course, prepare the leaders, and build capacities. In accepting these challenges, the UAFs have:

- established a standard of excellence in providing services to this distinct group of persons,
- provided interdisciplinary training to highly skilled specialists to ensure that the services they provide are in response to the total needs of the individual and represent the best of all relevant fields rather than a simple speciality, and
- initiated efforts to apply the outcome of clinical research to the state of the art knowledge upon which contemporary professional practice and services can be based.

In addition, the MRRCs are:

- involved in research aimed at understanding development and the identification, intervention, and treatment of abnormal development processes.

The UAF and MRRC report cards cover a wide array of performance measures. To fully appreciate the revolutionary nature of these activities, they must be taken in their historical context. Prior to the 1960's, the decade in which the UAFs and MRRCs were chartered, disabled people were widely regarded as devoid of social or economic value. As a result, these individuals were segregated from society at large, and programs to aid them provided "care", often of a mere life-sustaining nature, rather than "service" that would lead to economic productivity or higher quality of life in socially gratifying settings. Furthermore, many of these "care" programs required residential placement, which involved the disruption of family integrity. In our presentation we wish to highlight only a small number of the accomplishments for you and cite some of the priority "next steps" we recommend to realize the full benefits from these initiatives.

The UAFs and MRRCs have demonstrated that this social, and now legal, obligation can be successfully met. Their contribution to preserving and improving the quality of life of persons with chronic illness and disabilities may be seen in persons whose fragile medical status once dominated and limited their lives but who are now visible in a host of viable life experiences.

Example: Respirator dependent children, only recently confined to in-hospital care, are now participating in preschool programs

Example: Severely disabled persons who once were thought to have no alternative to a life of institutionalization are now in public school programs with their non-disabled peers and entering the work force as productive employees.

From a research perspective:

Example: A generation of children with PKU, a genetic disease which in an earlier time insured mental retardation, are now young adults of normal intelligence planning for their own families.

Example: Thousands of children at risk for familial mental retardation have participated in early intervention programs significantly enhancing their cognitive and social development.

Example: Biomedical scientists have developed interventions that are highly effective in preventing mental retardation from a few of the many biological causes, such as congenital hypothyroidism.

The UAFs and MRRCs played a significant role in these accomplishments.

Let's look at specific UAF and MRRC accomplishments for 1985.

In the UAFs......

- 62,421 persons with developmental disabilities were provided exemplary services. This included:
- 46,816 children and youth receiving prevention, early intervention, health care, treatment and evaluation services (a 19% increase over the previous year)
- 15,605 adults, who received services which increased their independence, productivity, and integration into the community.

10,871 UAF students and professionals were trained in UAFs in FY 85. This included:

- 1,215 trainees who received advanced, intensive training (300 - 600 hours) in leadership and interdisciplinary clinical competencies;
- 3,200 trainees receiving training (41 - 299 hours) in team practitioner and leadership competencies;
- 6,456 trainees trained in special interdisciplinary and developmental disabilities service applications.

In addition, UAFs also impact on students in other, related university programs and through continuing education by providing knowledge about the interdisciplinary process and DD related issues. In FY 1985, UAFs reached:

- 223,431 individuals, most of whom were professionals involved in the provision of services to multi-handicapped infants and children and their parents, participated in conferences, continuing education, workshops, and other special programs with UAF faculty;
- 35,230 college and university students received lectures and courses on developmental disabilities from UAF faculty as part of their course of study.

In the MRRCs.....

- over 500 scientists in University laboratories are conducting research on the causes and treatment of developmental disabilities;
- over 1500 graduate-level trainees in the health and basic sciences are being trained to continue the nation's research efforts to bring about increased understanding leading to eradication of developmental disease.
- since the MRRCs were created by the Congress, over 10,000 scientists have been trained within the MRRCs. Including the multiplier effect of scientists training new scientists, the training efforts at the MRRCs have primarily provided the personnel base for our national research effort on developmental disabilities.

As a result of these and other efforts during the past 25 years and focusing largely on children in the early years, we have witnessed substantial gains. Children, mothers, and families are healthier. We can document that early intervention with services and support to infants, children, and their families minimizes the consequences of the disability. However, we must enhance our capacity to serve this high risk population from birth, to extend our reach to fill this critical gap with a coordinated effort by the providers of health, education, and social services.

We are justifiably proud of the successes we have in meeting the needs of these unique individuals and we are now in a position to benefit from their value and contributions. In this case we find good news replaced with even better news.

The successes have created new challenges and opportunities now for a healthy, dynamic, and productive adult and aging population. The work must continue its emphasis upon the exploding knowledge and experience base with children, but now must expand to include the full life cycle of all persons with developmental disabilities.

The adult with disabilities presents different needs including housing, health, education and rehabilitation, employment, social and leisure opportunities. The interdependent needs of these persons require the same type of bold and effective leadership UAFs have provided in expanding services and programs for children. New service concepts, appropriate service models, and skilled leaders must complement the capacity of our services to ensure the continued growth and integration of these individuals. The UAF network's substantial expertise and involvement in the life family, community, and services for these persons, provides the vehicle to expand and ensure the continuing successful journey. Congress has created the means to fulfill the mission for the successful integration of all persons with severe disabilities into society and valued life opportunities.

Today, and in the future, the challenges which we must address include:

- o extension and expansion of services to infants and their families (from birth) to lessen the effects of the disabilities;
- o focus on the increased difficulty in the years of transition from childhood to adult;
- o obtaining access and entry into an array of services for adults who are developmentally disabled, to provide the

supports to enable them to achieve greater economic self sufficiency and social integration with the larger society; and

- addressing the unique need of ever increasing numbers of aging persons with developmental disabilities, who need adequate housing, assistance in accessing social supports, preventive and ameliorative health care, and companionship.

From the perspective of research, tremendous opportunities and serious new threatening diseases require effective and timely efforts. It is of greatest importance that the research community:

- apply the new developments in molecular biology and recombinant gene therapy to the problems of developmental disabilities. We have the opportunity to eradicate all developmental disorders that can be associated with the anomalous structure or function of a single gene;

- continue to develop new programs aimed at Fetal Alcohol Syndrome, a disorder leading to permanent impairment of a child brought about by the mother's consumption of alcohol during pregnancy;

- develop new research programs concerned with the pediatric onset of AIDS. AIDS has been shown to have an affinity for central nervous system tissue. If unchallenged, pediatric AIDS will lead to severe mental retardation and other disabilities.

The AAUAP programs supports the levels of appropriation recommended by the Consortium for Citizens with Developmental Disabilities (CCDD). These appropriation levels are conservative and realistic. Furthermore, they are consistent with the Congress' effort to reduce federal spending by promoting economic prosperity and encouraging reduced dependency on public support. Within the Developmental Disabilities field, it is that precise task to which the UAF program is directed -- early intervention, the promotion of independence and self sufficiency, improving the effectiveness and efficiency of our service delivery system, and preparing through training the professionals who will direct and provide the leadership for the future. That is the mission of the UAF program.

In summary, let me be specific in identifying the resources necessary at the federal level to accomplish this task:

1. Administration on Developmental Disabilities (ADD) support for the UAF program at $10.1 million

Appropriation of the recommended $10.1 million would allow the network to achieve funding stability for existing programs to enable UAFs to continue to address the program priorities we have outlined above.

2. Continuation of the support for ADD Special Projects at the level of $3.1 million

Funding for Developmental Disabilities Special Projects and Grants of National Significance is the sole source of ADD's directed research, demonstration, and development that specifically addresses the needs of persons with developmental disabilities. These funds are vitally needed to benefit services in ways that state funding cannot, such as facilitating coordination among federal agencies and providing nationwide technical assistance.

3. Continued Maternal and Child Health (MCH) support and retention of the full 15% setaside. We recommend raising the authorization and funding levels to $600 million.

The MCH Block Grant program provides assistance to state Crippled Children's and public health agencies which cannot serve families without such assistance. The recommended funding level will allow for the continued services critical to the health of needy mothers and their families who are chronically ill and disabled.

We urge that the full 15% "setaside" level of $90.0 million be retained for interdisciplinary training, applied research, and special programs to enhance the quality of health and overall care and treatment to persons with chronic disabilities and illnesses.

4. For the NICHD, we ask that $376.7 millions be appropriated to support research.

We cannot overstate the importance of research supported by the NICHD, and the critical role that agency plays in the national effort to promote the birth and development of healthy babies. The scientific community is making tremendous strides forward and is capable of significant and continued progress in this important area if sufficient resources are available. New research tools provided by molecular biology; new non-invasive imaging and other technologies; and new insights and intervention strategies provided by behaviorial scientists are available to bring about this progress. With the $377 million for the NICHD requested above, the following efforts can be initiated during the coming year by the MRRCs and the UAFs working together.

1. A prospective study of very low-birthweight infants.

These infants are at great risk for developing mental retardation and other developmental disabilities. This effort will allow us to understand how these infants develop and to develop procedures to provide prevention and interventive services to foster optimal development;

2. Studies of infants and aging persons with Down Syndrome. Because of improvements in medical technology, persons with Down Syndrome, one of the most prevalent genetic causes of mental retardation, are living longer into adulthood. These individuals have not, however, been the benefactors of sufficient research to develop effective early intervention programs and programs aimed at understanding the early onset of Alzheimer's-like conditions;

3. New research on self-injurious behavior in persons with mental retardation. Although this injurious behavior is one of the most common problems among severely and profoundly retarded persons, past research efforts have not made significant progress. It is believed a large-scale effort involving both the MRRCs and the UAFs would facilitate the solution to this problem;

4. A collaborative study of persons with Fragile-X Syndrome. Recent genetic research has uncovered a genetic syndrome associated with mental retardation which is about one-half as prevalent as Down Syndrome in males. The disorder is always associated with a marr on the X-chromosome, but little else is known about it. This study among the MRRCs and the UAFs would contribute to more rapid acquisition of knowledge on this disorder.

These are exciting opportunities that will have a great impact on the societal and fiscal consequences of developmental disabilities. The MRRCs and the UAFs have already had planning meetings to coordinate these national efforts. However, these collaborative studies depend upon sufficient research support for the NICHD. None of these efforts can happen if the support of the NICHD is limited to the magnitude at or near the level requested by the administration in its budget request.

In summary, the commitment that Congress and society made to individuals with handicaps was not a short-term commitment. It was not meant to be fulfilled just when times were good. This commitment was a long-term investment in our nation's future. Our request, Mr. Chairman is for your assistance in continuing the fiscal support necessary to ensure that this commitment is fulfilled.

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WEDNESDAY, MAY 7, 1986.

NICHD

WITNESS

DR. MAURICE E. KEENAN, AMERICAN ACADEMY OF PEDIATRICS

Mr. NATCHER. Our next witness is Dr. Keenan. Come around, Doctor.

Dr. KEENAN. Good afternoon.

Mr. NATCHER. Doctor, you have been before our committee before. We are delighted to have you back, and we will be pleased to listen to you.

Dr. KEENAN. My name is Maurice Edward Keenan. I am a pediatrician at Massachusetts General Hospital in Boston, Massachusetts. Today, I am here representing the American Academy of Pediatrics.

As a departure from the Academy's usual request for specific funding levels for a variety of categorical programs, this year we chose to focus on a central theme, infant mortality and morbidity.

We have chosen this approach for two reasons. One, the United States ranks 15th among nations in our infant mortality rate, a level similar to that of Singapore; and, two, the programs over which this committee has jurisdiction have played a significant role in reducing infant deaths.

The current climate regarding crucial maternal and child health programs, which are demonstrably effective and economical, puts mothers and their children at risk. American children today do not have the same problems as infants and children 15 to 20 years ago.

Today's infants are poorer; one-fifth of U.S. children live below the poverty line, and 21 percent live in single-parent households. Emergency rooms and drop-in clinics are becoming the chief source of care for families of the working poor who have lost medicaid benefits and have no private insurance.

Basic problems persist, and they discredit us all. If we look at the survival rates of newborns as an indicator of how well our society cares for its most vulnerable members, regrettably our national infant mortality rate for 1984 was 10.6 deaths per 1,000 live births.

With approximately 3,500,000 births in this country per year, that translates into 40,000 infants dying during their first year of life. Of these 40,000 deaths, 70 percent die during the neonatal period; that is, the first 28 days of life.

More than two-thirds of those deaths are among low birth weight infants, infants weighing less than 5 and a half pounds. Low birth weight babies have a death rate 200 times greater than that for normal infants.

Unquestionably, the factors contributing to infant mortality are complex and overlapping. However, solutions are within reach. Not all infants can be saved from death or disability, but many more should have a healthy life.

Short-term and long-term strategies must be considered by Congress if progress is to be made. Many of these involve the obvious. Pre-natal mothers must receive adequate nutrition and care, further research must be provided, and children must be immunized. In short, all efforts to prevent avoidable deaths or disability among infants must be taken.

All programs impacting upon children play a role, some more important than others. However, today I would like to focus my comments on two areas which merit most of our attention.

One such area is the Federal Childhood Immunization Program, the most basic and successful preventive health program on the Federal books. It was dirt cheap and it gave us tremendous, tremendous help for our children.

Yet the budget proposal falls dangerously short. Millions of dollars in funding cuts can cost the nation hundreds of millions of dollars in health care expenditures, not counting suffering and loss of potential.

Vaccine prices, due to insurance and liability costs, continue to soar. In fact, the cost of fully immunizing a child today has risen from $6 in 1982 based on what this budget in previous years has taken into account to more than $30 today, a 500 percent increase in four years. Prices for 1987 may go up another 50 percent.

Unfortunately, while the costs of immunizations have gone up steeply, the budget for Federal childhood immunizations has not. The number of children to whom the government can provide vaccine has declined by two-thirds.

The Academy urgently recommends that Congress reinforce its support for the Federal Childhood Immunization Program. We cannot allow children to be disabled and face death due to diseases that should never have occurred. We simply cannot afford to treat children for the crippling conditions that are perfectly preventable.

The second area I would like to emphasize is research. The pediatric community is pleased to join others in support of a $6,000,000,000 NIH appropriation for fiscal 1987. Additional support for basic research rests on the premise of the long-term economic strength of this nation, and the continued improvement and well being of its people demand a sustained investment in scientific research in our investigators.

Let me single out the activities of the NICHD, the National Institutes of Child Health and Human Development, which are particularly pertinent. Understandably and rightly so, they are involved in expanded research activities in the prevention of the low birth weight infant.

Another priority at NICHD are new vaccines for illnesses of infancy and childhood. Special attention must be directed to pertussis vaccine.

NICHD intramural scientists have recently isolated and purified the single component of pertussis organisms which they believe is sufficient to produce a desirably safe and effective vaccine. They are about to start field trials, but an additional $1,000,000 must be targeted to continue these trials. I know how everyone hates to earmark funds, but I again reiterate the need to earmark $1,000,000 for this promising pertussis research.

We should be proud of what our government has done for us. It is very expensive to continue on in this mode. I am proud to be an American. Thank you very much for listening to me.

[The statement of Dr. Keenen follows:]

American Academy of Pediatrics

TESTIMONY

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES AND EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES

ON

PROGRAMS IMPACTING INFANT MORTALITY/MORBIDITY

PRESENTED BY
Maurice E. Keenan, M.D., F.A.A.P.
May 7, 1986
3:10 P.M.

Office of Government Liaison
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Mr. Chairman, my name is Maurice E. Keenan, M.D., a pediatrician in private practice from West Newton, Massachusetts, here today representing the American Academy of Pediatrics. Even in the onerous era of Gramm-Rudman, it is a pleasure for me to appear before you this morning. Members of the appropriations panel have been steadfast advocates for children over the years and I have every confidence that this commitment will continue.

It must. Crucial maternal and child health programs -- programs which are demonstrably effective and economical -- remain at risk in the current climate, as Congress weighs across-the-board cuts against more targeted savings for fiscal 1987. The case for careful assessment is powerful and can be captured concisely: INFANT MORTALITY AND MORBIDITY.

With more and more solid information available now on the vulnerabilities of children, especially babies, it is unimaginable that members of Congress would sharply diminish their support for federal initiatives which help address these serious maternal and child health problems. Indeed, after five years of belt-tightening, increased attention and bold innovation are all the more necessary.

American children today do not have the same problems as children had 15 or 20 years ago because they aren't the same kind of children. Today's children are poorer, relative to the rest of society, than children of the 1960s were. One-fifth of U.S. children live below the poverty line and 21 percent live in single-parent households. Emergency rooms are becoming the chief source of care for families who have lost Medicaid benefits and have no private health insurance. Hence, attempts to assist children are fragmented, sporadic and take place in the absence of an overall context or well-established sense of priorities. Consequently, children suffer disproportionately in times of fiscal cutbacks and program consolidation. It is important to appreciate the uncertain position of pediatric programs in 1986 because it is from here that we enter a new era of sweeping change in our health care system.

Basic problems persist, and they discredit us all. The survival rates of newborn infants serve as an indicator of how well a society cares for its most vulnerable members. Regrettably, our national infant mortality rate for 1984 was 10.6 deaths per 1000 live births, ranking the United States only 15th among nations having a population greater than 2 million. With approximately 3.6 million births in this country annually, nearly 40,000 infants will die during their first year of life.

Roughly 70 percent of these deaths occur during the neonatal period, the first 28 days of life. By far the greatest risk for neonatal death is among low birth weight (LBW) infants, those weighing less than 2500 grams (5.2 pounds). More than two-thirds of deaths in the neonatal period occur among LBW infants. The risk of neonatal death for LBW infants is 200 times higher than that for normal birth weight infants.

It is therefore of profound concern to the Academy that current national policy has been but marginally effective in reducing the proportion of LBW infants. The decrease in the incidence of LBW deliveries from 7.7 (per 1000) in 1960 to 6.8 in 1983 represents only a 14-percent decline. (Post neonatal mortality, deaths from 28 days to one year of age, accounts for the remaining 30 percent of infant deaths -- and fully 20 percent of these deaths occurs among former LBW infants. The remainder are related to environmental conditions and infectious diseases. Sudden Infant Death Syndrome accounts for 33 percent; infections, 10 percent; accidents, 7 percent.)

Unquestionably the factors contributing to infant mortality are complex and overlapping, but solutions are within reach. Though not a medical problem, poverty is a significant factor affecting the health and well-being of women and children. Poverty has not only increased in recent years but it has become more severe in degree. If poverty cannot be eliminated, the next best option is to selectively address the situations leading to high-risk births and to intervene at key points. Sharp variables in addition to poverty which bear on the potential for deliveries of LBW infants include maternal age, access to prenatal care, health insurance, support of extended family, wanted versus unwanted pregnancy, availability of contraception, and access to counseling.

The answer to the dilemma, as complex as it may be, is a collaborative commitment by policy makers, health care professionals from a variety of disciplines and corporate and community leaders to make infant mortality and morbidity a priority deserving special attention and immediate action. Steps by both the public and private sector need to be taken. Not all infants can be saved from death or disability, but many more could have a healthy life.

There are short-term and long-term strategies that leaders must institute if progress is to be made. And many of them involve the obvious, e.g., prenatal mothers must receive adequate nutrition; further research must be promoted; children must be immunized. In short, all efforts to prevent avoidable deaths or disabilities among infants must be taken.

Federal support for vital maternal and child health programs over the years cannot be underestimated -- Congress at least has helped limit problems associated with infant mortality. Still more needs to be done, however, and Gramm-Rudman must not be permitted to tighten the clamp on a funding squeeze already five years too old.

This testimony will focus on a variety of programs that influence infant mortality and morbidity in the United States directly or indirectly. The Academy will not -- cannot -- choose among them to help members of Congress apportion imprudent and improvident cuts. Mothers and children did not double the national debt since 1981, and given the lamentable level of infant mortality and morbidity, they cannot now be conscionably sacrificed at the altar of misplaced priorities. Each of the following areas of federal funding makes a special contribution to the ongoing battle against infant mortality and morbidity. Each is worthy of continued, even increased support. As are all American children.

IMMUNIZATIONS

The Federal Childhood Immunizations Program has been a remarkable success by any measure -- millions of dollars in funding cuts today could cost the nation hundreds of millions of dollars in health care expenses tomorrow.

But vaccine prices, owing substantially to insurance and liability costs, continue to soar. In fact, the price for vaccines to fully immunize a child has risen from $6 in 1982 to more than $30 today -- a 500-percent increase in four years. Prices in 1987 may rise another 50 percent. Unfortunately, while costs of immunization have gone up steeply, the budget for federal childhood immunizations has not. The number of children to whom the government can provide vaccine has declined by two-thirds. If the President's budget for 1987 were adopted by the Congress, states would be able to supply vaccine for still 400,000 fewer children.

As startling as these numbers are, they tell only part of the story. States, faced with skyrocketing vaccine costs, are being forced to lay off immunization workers, leaving clinics and medical-records work unstaffed. They are beginning to implement copayments for the poor, some as high as $15 per shot. And the President's budget proposes no funds for the yet incomplete vaccine stockpile, even though mere months ago we were forced to ration childhood vaccines in this country.

All of these problems are compounded by Gramm-Rudman. The first round of relatively shallow cuts eliminated funds for more than 65,000 children's shots. Every percentage point cut from 1987's budget will mean another 10,000 children without federal vaccinations. If present deficit forecasts are accurate, hundreds of thousands of children may be eliminated from the program.

The Academy urgently recommends that Congress reinforce its support for the Federal Childhood Immunization Program. We cannot allow children to die of diseases that should never occur, and we cannot afford to treat children for crippling conditions that are perfectly preventable.

NIH Research

The pediatric community is pleased to join with the 125 member organizations of the Ad Hoc Group for Medical Research Funding in support of a $6.079 billion appropriation for NIH for fiscal year 1987. Additional support for basic research rests on the premise that the long-term economic strength of this nation and the continued improvement in the well-being of its people demand a sustained investment in scientific research and in our investigators. While we recognize and applaud the attention given by the various institutes to the areas of maternal and child health, our comments will center on the National Institute of Child Health and Human Development (NICHD), the focal point of these critical efforts.

To stint funding for this Institute is untenable. Even during a time of shrinking budgets, it is shortsighted to decrease monies for the Institute directed at preventing disability and death during the critical period surrounding infancy and the ensuing childhood years. In the area of child health research we stand at an important crossroads where new medical opportunities exist. Through your leadership, let us be far-sighted enough as a nation to take advantage of these recent developments.

Among special emphasis at NICHD today, understandably, are expanded research activities in the prevention of low birth weight. The program includes increased research on intrauterine growth retardation (IUGR) and prevention of premature labor, the two factors responsible for low birth weight.

New vaccines for illnesses of infancy and childhood are another top priority. Whooping cough, typhoid fever and meningitis due to Hemophilus influenzae are still responsible for illness, death or permanent disability in many children. Special attention must be directed to pertussis vaccine. NICHD intramural scientists have recently isolated and purified the single component of the pertussis organisms which they believe is sufficient to produce an entirely safe and effective vaccine. Now they are about to start field trials of their new vaccine in Sweden, where without vaccine use pertussis has reached epidemic proportions. An additional $1 million must be targeted to continue these important trials.

Despite effective antibiotics, H. influenzae remains a serious cause of sickness and death in infants, and is a leading cause of acquired mental retardation in this country. A recently licensed vaccine based on earlier work of these NICHD scientists is effective in older children but not in those under two years of age, the time of greatest risk. They have now produced a modified vaccine intended for use in the younger age group, and studies are under way to test its effectiveness.

Once infancy is past, injuries, not disease, become the leading cause of death and disability. Here again prevention is of paramount importance. Preventive approaches involve both pediatrics and the behavioral sciences. For example, studies supported by NICHD have developed and demonstrated the effectiveness of pediatric office-based interventions which prod parents to use car seats and seat belts for their children, and lower their home hot-water heater settings to prevent scalding. To expand this research, NICHD last year issued a special solicitation for research grant applications on behavioral approaches to injury prevention. More attention must be focused on this area.

Maternal and Child Health Block Grant

The MCH block on a lean budget continues to do important work through its component programs: Title V Maternal and Child Health/Crippled Children's Services; Lead-Based Paint Poisoning Prevention; Sudden Infant Death Syndrome; Supplemental Security Income Program for Disabled Children; Adolescent Pregnancy Services; Genetic Diseases Program; and Hemophilia Diagnosis and Treatment Centers. But increased support is necessary, especially if the Administration successfully caps federal funds for Medicaid.

Dramatic cost shifting from other health programs, cutbacks in needed services or both would occur. Experience tells us that children would bear an unfair share of this burden. With increased fiscal pressures on Medicaid, a growing number of young mothers and children may be forced to turn to the services provided by the maternal and child health block, services already stretched to capacity. At particular and growing risk are the "new" poor, who face a void in maternal and child health services.

Emergency Medical Services for Children

Nearly 18 million children receive emergency medical services annually with as much as 55 percent of all deaths up to age 15 due to injuries. Congress recognized the imperative need to improve emergency medical services to children when it authorized funds for demonstration programs for emergency medical services for childen as part of the Preventive Health Services Block. Although the Administration budget proposes to eliminate these programs, we believe a more haphazard approach could lead to longterm disabilities or deaths, an expensive price for society to bear by any definition.

Head Start

Research findings on the effects of early childhood education demonstrate increased school success, increased employment potential, reduction in dependence on public assistance, decreased criminal activity and positive effects for parents and families of children who attended preschool compared with children who had not. A $1 dollar investment in preschool education returns $4.75 in savings.

Head Start, owing to its comprehensive nature which incorporates health, nutrition, social services, education, parent involvement and services for special-needs children, is the most successful federal preschool program. The commitment of parents, staff and community to the Head Start program attests to its importance. The Academy believes that Head Start should continue to be funded at its current level.

Primary Care Training

In spite of the Administration's proclamation that health professions subsidies are no longer necessary and program termination imposes no cost to society, such is most certainly not the case for primary care education. The need for adequate support of pediatric primary care training grants, as supported through the Public Health Service, is pressing.

Primary care is the most comprehensive, cost-effective way of providing health care. Primary care reduces the occurrence and subsequent need for more expensive tertiary consultation and inpatient care. In fact, most primary care pediatricians see patients on an ambulatory basis.

In conclusion, let me reemphasize that inferences must be drawn from our infant mortality rate which go beyond the immediate components of the measure, i.e., death to infants under one year of age, which speak to risks, needs and services for infants, children and young families. While this statement stresses the medical and health components, many other programs influence infant mortality and morbidity and deserve your attention and support. These include Medicaid, WIC, Family Planning, AFDC, Child Abuse, Developmental Disabilities, Migrant and Rural Health, Indian Health and Child Care. All play a role. One cannot be sacrificed for another. Changes in the measure of infant mortality and morbidity which can be sustained over time will not occur without diligent and continued attention to these several major influences on the health of this population.

As a society, we simply cannot afford the wastage of human resources in childhood and adolescence. As pediatricians, we feel it is incumbent upon us to present to you in this context the opportunities we share to shape healthy and productive adults.

SUMMARY OF RECOMMENDATIONS

AMERICAN ACADEMY OF PEDIATRICS

($ in Thousands)

	FY 86 APPROPRIATION	FY 86 G-R-H REDUCTION	FY 87 PRESIDENT'S REQUEST	AAP REQUEST
1. Childhood Immunization Program	59,500	-2,500	56,000	98,000
2. Maternal and Child Health Block Grant	478,000	-20,554	478,000	478,000
3. National Institutes of Health	5,498,000	-236,414	4,936,000	6,079,000
National Institute of Child Health and Human Development	321,796	-13,838	309,119	376,745
4. Pediatric Emergency Medical Services	2,000	----	-0-	2,000
5. Primary Care Training Grants Internal Medicine/Pediatrics	18,500	-796	0	18,500
6. Head Start	1,087,000	-47,000	1,075,000	1,087,000

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Severe Primary Malnutrition in US Children

Robert Listernick, MD; Katherine Christoffel, MD, MPH; Jimmie Pace, MA; Janet Chiaramonte

• We studied 16 children aged 18 months or less who had severe primary protein-calorie malnutrition. All were admitted to one urban pediatric teaching hospital for treatment of failure to thrive between Jan 1, 1980, and Aug 30, 1984. The definitions of malnutrition were based on those of the Wellcome Trust. The patients had no evidence of medical causes for their conditions and grew rapidly when they were refed in the hospital. Eight were products of teenage pregnancies. Eleven patients were receiving public aid, and four had no third-party coverage. All were markedly below the fifth percentile in weight for length; their mean percentage of expected weight for age was 0.55. The mean hospital stay was 18.5 days. Severe primary protein-calorie malnutrition does exist in the United States. Thorough nutritional evaluation in children with failure to thrive is indicated, and malnutrition should be a reportable condition in the United States.

(*AJDC* 1985;139:1157-1160)

Protein-calorie malnutrition (PCM) is epidemic in developing countries. Approximately 65% of the children under the age of 5 years in Central America have weight deficits for age that suggest PCM, and over 50% of deaths in children under the age of 5 years in these countries have been linked to PCM.[1] In developing countries the vast majority of children with PCM are malnourished because they do not eat enough food (primary PCM, or PPCM).

It is increasingly recognized in industrialized nations that PCM occurs among patients hospitalized with severe or chronic disease (secondary PCM).[2,3] However, PPCM occurs in technically advanced countries as well, although its prevalence is unknown.[4-9] Children in the United States who are seriously malnourished reach that severe state in part because they have not been involved in the existing health care services system. As a result, usual surveillance mechanisms in the United States (eg, public health clinics) generally do not identify children with PPCM. Such children usually come to attention only when they present for acute medical care, at which point they are seriously ill. As a result, estimation of the prevalence of severe PPCM in the United States depends in large part on hospital-based studies.

A problem more commonly recognized than PPCM in urban hospitals in the United States is nonorganic failure to thrive (NFTT).[10,11] The term NFTT may be used to describe the presenting complaint of a heterogeneous group of children.[12] Pediatricians also use NFTT as a diagnosis of exclusion after an exhaustive search for an organic cause of growth failure has been made.[13] The degree of nutritional depletion of children with NFTT is often overlooked because their nutritional assessment is not thorough. As a result, hospital-based information concerning severe PPCM has been unavailable.

We describe 16 children with severe PPCM hospitalized at one urban pediatric teaching hospital in a 4½-year period. Although all the children had a discharge diagnosis of NFTT, none had a nutritional assessment at the time of admission adequate to document the severe degree of nutritional depletion.

PATIENTS AND METHODS

Patients with severe PPCM were identified retrospectively by one of two methods: (1) a review of cases referred to the protective services team for failure to thrive (FTT) due to environmental deprivation from Jan 1, 1980, to Aug 30, 1984, and (2) a medical audit of patients under 18 months of age in one 12-month period with a recorded discharge diagnosis of NFTT. Children whose malnutrition was thought to be consequent to an organic cause (secondary PCM) were excluded. The ages of children born prematurely (<37 weeks' gestation) were corrected appropriately.

Definitions of severe PCM were those of the Wellcome Trust,[14] using National Center for Health Statistics standards. *Marasmus* was defined as less than or equal to 60% of expected weight for age without edema or hypoalbuminemia; *marasmic kwashiorkor*, less than or equal to 60% of expected weight for age with edema or hypoalbuminemia; and *kwashiorkor*, 60% to 80% of expected weight for age with edema or low albumin level. The Wellcome Trust definitions were adapted minimally, eg, to include hypoalbuminemia as equivalent to edema (since infants may not evidence edema as consistently as weaned children).[15] The percentage of expected (median) weight for age was calculated using the formula (weight at admission/median weight for age) × 100. Another measure, the weight index, was calculated using the formula (weight on admission/median weight for age)/(length on admission/median length for age).[16]

RESULTS

We identified 16 children with severe PPCM (Table 1). Severe malnutrition had not been recognized in any child during the hospitalization. Nine of the children were hospitalized after 1982. Fifteen children were found to have marasmus; at least one child had marasmic kwashiorkor (in four patients no albumin measurement was available). Mean age at admission was 8.3 months. Nine children had been premature, three of whom were prod-

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From the Departments of Pediatrics and Social Work, Northwestern University Medical School, Chicago.

Read in part before the House Select Committee on Hunger and the Energy and Commerce Subcommittee on Health and the Environment, Washington, DC, May 23, 1985.

Reprint requests to Division of General and Emergency Pediatrics, Department of Pediatrics, Northwestern University Medical School, The Children's Memorial Hospital, 2300 Children's Plaza, Chicago, IL 60614 (Dr Listernick).

Table 1.—Clinical Profiles of 16 Patients With Severe Protein-Calorie Malnutrition

Patient/Age, mo*/Race*/Sex	Weight				Albumin, g/dL	Hospital Stay, Days	Discharge Weight, kg	Diagnosis
	Birth, kg	Admission, kg	% of Expected for Age†	Index†				
1/14(11)/H/F	1.10	5.14	0.55	0.61	4.3	15	5.52	Marasmus
2/10/W/F	2.73	5.06	0.57	0.72	. . .	10	5.32	Marasmus
3/18(15)/B/M	1.07	6.41	0.56	0.66	. . .	15	6.92	Marasmus
4/3/W/M	2.50	3.18	0.53	0.59	. . .	10	3.38	Marasmus
5/8/B/M	3.86	5.06	0.57	0.86	4.4	8	6.11	Marasmus
6/9/W/F	3.57	4.60	0.54	0.59	4.5	17	5.44	Marasmus
7/3/B/M	3.30	3.52	0.59	0.60	3.8	27	3.92	Marasmus
8/2/W/M	3.04	2.64	0.51	0.55	3.3	17	3.06	Marasmus
9/14(13)/B/M	1.68	5.78	0.56	0.58	4.3	21	7.96	Marasmus
10/10(8)/B/F	1.08	4.34	0.53	0.61	. . .	12	5.03	Marasmus
11/7(6)/W/F	2.66	3.56	0.49	0.56	4.6	23	4.58	Marasmus
12/2/B/M	2.70	2.49	0.48	0.56	2.8	47	3.40	Marasmic kwashiorkor
13/7(6)/B/M	2.33	4.64	0.59	0.66	4.2	14	5.00	Marasmus
14/10(9)/H/F	1.82	4.88	0.57	0.61	4.3	16	5.14	Marasmus
15/10(8)/B/M	1.64	4.50	0.55	0.63	4.1	30	6.26	Marasmus
16/6(5)/H/F	2.40	3.52	0.53	0.38	4.4	14	4.38	Marasmus

*Ages in parentheses are corrected gestational ages used in calculating expected weight for age. W indicates white; B, black; and H, Hispanic.
†Definition given in text.

ucts of twin gestations.

There were eight black, five white, and three English-speaking Hispanic patients. None was a recent migrant to the area whose caregiver might be unfamiliar with local support services. Eleven patients were receiving public aid, one had commercial insurance, and four had no means of payment. In general, the patients were the most recent children born into large sibships and had no ongoing source of medical care (Table 2). Information was available for 13 patients concerning coverage by the Special Supplemental Food Program for Women, Infants, and Children, Public Law 92-433 (WIC); only three were enrolled in the WIC program prior to hospitalization.

All of the patients were markedly below the fifth percentile in weight for length on admission to the hospital. The mean weight on admission was 4.33 kg (Table 3). The mean percentage of median weight for age was 55%; the mean weight index was 0.62. The average hospital stay was 18.5 days. Average weight gain was 44 g/day. The Illinois Department of Children and Family Services was involved in all the cases; nine children were ultimately placed in foster care. However, the precise reasons for inadequate caloric intake at home usually remained unclear.

COMMENT

Protein-calorie malnutrition refers to a heterogeneous group of nutritional deficiency states.[17] Mild degrees of PCM may be inapparent without careful evaluation. The signs and symptoms of severe PCM are familiar to health professionals in developing countries, but they are unfamiliar to many in the United States.

Marasmus results from a prolonged deprivation of both calories and protein. Marasmic children appear emaciated; their skin seems to hang from their bodies. They have absent buccal fat pads, sunken cheeks, and sparse, brittle hair, giving them the appearance of "wizened, little old men."[18] Kwashiorkor is believed to result from a diet disproportionately deficient in protein.[1] The typical appearance of children with kwashiorkor is one of irritability, generalized edema, hepatomegaly, and a characteristic hyperpigmented, hyperkeratotic desquamating rash ("flaky dermatitis").[1] As such infants often appear "fat," their protein deficit can go unsuspected. The term *marasmic kwashiorkor* is used to describe children who display features of both conditions.[14]

Although severe PPCM clearly occurs in the United States, it has rarely been described. Underrecognition of severe PPCM may have stemmed in part from the lack of awareness of proper nutritional assessment techniques. The degree of malnutrition was unrecognized in all the children we describe herein; serum albumin was measured in only 75%. No child had the thorough nutritional assessment required for documentation of malnutrition.[19-22] A recent study of children with NFTT included no measurements of the degree of malnutrition other than weight and length.[23,24]

Thorough nutritional assessment of children with NFTT is warranted for three reasons. First, the nutritional status of malnourished children affects their care during initial nutritional rehabilitation. Severely malnourished children are at great risk for developing nosocomial infections.[25,26] Lactose intolerance[27] and congestive heart failure (particularly when associated with anemia)[1] may complicate the refeeding period. Sudden death may occur in severely malnourished children who are rapidly refed with high-caloric-density formulas.[28] Thus, the choice of an appropriate refeeding program may affect patient morbidity and ultimate prognosis. Second, severe malnutrition in infancy can result in the attenuation of normal brain growth[29,30] and affect ultimate intellectual outcome.[1] This may explain some of the poor developmental outcomes usually

Table 2.—Social Characteristics of 16 Children With Severe Protein-Calorie Malnutrition

Patient	Financial Status	Family Constellation	Usual Source of Medical Care	Ordinal Position Among Sibs	WIC* Active	Social Disposition
1	IDPA†	Unmarried parents live together, 4 sibs	None	3-4/5‡	. . .	Foster home
2	Cash	Married parents, 6 sibs; 1 sib in foster care	None	7/7	No	Court supervision in home
3	IDPA	Unmarried parents live together, 2 sibs	None	2/3	. . .	Home
4	Cash	Unmarried parents at home, 2 sibs in Canada, 2 at home	None	5/5	No	Court supervision in home
5	IDPA	Single mother, 1 sib, maternal grandmother, 6 unrelated children	Clinic physician	2/2	No	Court supervision in home
6	Commercial insurance	Parents married, 2 sibs	Private physician	3/3	No	Home
7	IDPA	Father in jail; mother and sib live alone	None	2/2	Yes	Court supervision in home
8	Cash	Married parents	None	1/1	No	Foster home
9	IDPA	Single mother, 4 sibs	Board of Health	3-4/5‡	Yes	Foster home
10	IDPA	. . .	Clinic physician	. . .	. . .	Foster home
11	Cash	Unmarried parents at home, 1 sib	Board of Health	2/2	No	Court supervision in home
12	IDPA	Single mother, 3 sibs, live with mother's sister and 3 children	None	4/4	No	Foster home (grandmother)
13	IDPA	. . .	Board of Health	3-4/4‡	Yes	Court supervision in home
14	IDPA	Single mother, 1 sib	None	2/2	No	Foster home (grandmother)
15	IDPA	Single mother, 2 sibs	None	3/3	No	Home
16	IDPA	Single mother, 3 sibs	Private physician	3/3	No	Foster home

*WIC indicates Special Supplemental Food Program for Women, Infants, and Children.
†IDPA indicates Illinois Department of Public Aid.
‡Twin sib.

attributed to family dysfunction.[20] Finally, recognition of PPCM is a necessary step toward identification of its causes. Recent increases in WIC funding appear to have reduced the prevalence of severe PPCM in Chicago children, but such a relationship cannot be established convincingly or disproved until systematic approaches to identifying malnutrition exist.

Previously reported cases of severe PCM in the United States have focused on kwashiorkor and on children affected by inappropriate feeding techniques.[4-9] In contrast, most of the children we describe had marasmus; the precise reasons for the inadequate caloric intake usually remained unclear. The available information suggests that inadequate accessibility of food was an important factor. In general, the children came from single-parent families receiving public aid with no routine source of medical care. This was true even of the children born prematurely, whose existence and circumstances were known to the health care system in the perinatal period. Most of the children would have been eligible for WIC, yet few of the families were receiving assistance from this program. It appears that concurrent lack of appropriate nutritional products and routine health care allowed the malnutrition of our patients to reach an advanced state. The reasons for this compounded failure require identification and correction.

In a recent commentary, Graham[21] suggested that concerns about chronic malnutrition in the United States may be unfounded. The children in this report make it clear that severe primary malnutrition associated with poverty exists in the United States. William Bithoney, MD, testified before the House Select Committee on Hunger in Washington, DC (May 13, 1985), that ten of 13 patients with third-degree malnutrition seen in his Growth and Nutrition Clinic in Boston during one nine-month period were poor. Two considerations lead to the conclusion that these cases may represent a larger group of severely malnourished children. First, our Chicago cases all were treated at one hospital in a city that has more than 80 hospitals. Second, even in drought-stricken Mauritania, where malnutrition is epidemic, *severe* malnutrition is rare.[22]

Table 3.—Summary of Clinical Data

	Mean ± SD
Age, mo	8.3 ± 4.6
Weight, kg	4.33 ± 1.1
% of expected weight for age	55 ± 3.2
Weight index	0.62 ± 0.08
Hospital stay, days	18.5 ± 9.7
Weight gain, g/day	44.4 ± 33

Poverty may lead to malnutrition in a number of ways. The social disorganization and stresses associated with poverty can lead to underfeeding due to abuse or neglect. Inadequate financial resources can result in inadequate amounts of food in the house, leading to modest or severe chronic nutrient inadequacy. Adequate food may be available in principle but inaccessible due to bureaucratic obstacles, unavailability of transportation, or family disorganization. The common intervention of foster placement is a nonspecific remedy that may correct problems resulting from either a family's internal functioning or its adverse situation in society. Clinicians and policy makers must find ways to distinguish the level of dysfunction and to develop specific remedies.

CONCLUSIONS

The exact relationship between the availability of food, malnutrition, and poverty in the United States remains unclear. However, they appear to be intimately connected. Further investigation to ascertain the prevalence and epidemiology of malnutrition in the United States is warranted. To this end and to improve patient care, at least three measures are needed. (1) As the term "failure to thrive" is vague and often obscures the existence of malnutrition, it should be discarded. (2) Children admitted for "failure to thrive" should undergo a thorough nutritional evaluation, including anthropometric and biochemical measurements. (3) Clarification of the scope of the public health problem of malnutrition would be promoted by making PCM a condition reportable to the Centers for Disease Control, Atlanta.

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Mr. NATCHER. Thank you very much, Doctor. You have given us a good statement.

WEDNESDAY, MAY 7, 1986.

NATIONAL INSTITUTES OF HEALTH

WITNESS

CYNTHIA NULL, FEDERATION OF BEHAVIORAL AND PSYCHOLOGICAL AND SCIENCES

Mr. NATCHER. Ms. Null, we will be glad to hear from you now.

Ms. NULL. I am Dr. Cynthia Null, Executive Director of the Federation of Behavioral, Psychological and Cognitive Sciences, a coalition of 13 scientific societies.

Mr. Chairman, I know we share the belief that maintaining a strong Federal role in basic research is important to this nation, even as the Congress is taking major steps to reduce the Federal deficit.

Research results cannot be bought on a short time scale. Neglecting basic research this year means fewer gains in subsequent years. We will not be able to remedy this deficit in knowledge by increasing research spending at a later time.

Good research requires attracting good people to work on important problems, and the training of new researchers, obtaining basic results and working out their applications. None of this can be done quickly. The investment in ideas, methods and applications must be done now.

Behavior is a key factor in the successful health promotion and in disease prevention. Basic behavioral science research is critical to maintaining and improving the health of our nation's people.

Today I will briefly mention behavioral research at NIA and NICHD, and with more time, I would talk about important research from many other institutes. For example, heart, lung, blood, cancer, eye, dental, environmental health sciences.

The population of those over 75 years old increased by 40 percent in the seventies, and is continuing to do so. Given the blessing of longer lives, the important question is becoming how healthy, active and independent will these lives be.

For example, seeing must be evaluated in the context of everyday activities. The standardized eye chart may be a good measure of visual acuity under ideal eye examination situations, but in elderly people, whose vision has been corrected using an eye chart, may fail to see even large objects under certain lighting conditions. We must come up with better ways of looking at vision, especially in the aged population.

For the elderly, nothing is more terrifying and life altering than Alzheimer's disease. Projections are we will go from 1,500,000 million patients with dementia today to about 8,500,000 million patients in the middle of the next century. Behavioral scientists are an important part of NIA's extensive research on Alzheimer's disease, measuring cognitive decline, developing early detection techniques and investigating causes and treatment.

Children are our future. Research sponsored by NICHD has improved our understanding of both normal and abnormal development. Currently the field of cognitive development is enjoying a period of unprecedented growth.

A few areas of interest: An important distinction is being made between having knowledge and using it, for thinking and problem solving. Research is currently needed on the cognitive development during adolescence.

NICHD has sponsored research on vision during infancy, and it should be continued and expanded into childhood and adolescence. Research on other senses, pain, taste, hearing, smell and touch need to be extended, not only in quantity but through all of childhood.

Another area of importance is prenatal exposure to drugs, alcohol, cigarettes, and the effect this has upon behavioral development and its relationship to later learning disabilities. Important research must continue on infants born at risk.

One such risk is Sudden Infant Death Syndrome which kills about 7,000 infants yearly. Research is needed which would test hypotheses stemming from a closer consideration of psychological and environmental influences that may be implicated in SIDS.

Mr. Chairman, we wish to commend the leadership you and this subcommittee are taking in important and promising research on health and behavior. Research designed to explore relationships between behavior, the nervous system, and the immune system is in its infancy.

Behavioral immunology is one of the most exciting developments in recent years and promises to yield great insight into the relationships between psychological factors, the nervous system and the disease process.

The administration's fiscal year 1987 budget request for NIH is very disappointing. We are sympathetic with deficit reduction efforts. However, we believe that the health of the people of this nation is too important to have research at NIH cut so drastically.

We are, of course, concerned that the approximately 3 percent of the NIH funds which go to support behavioral and social science research should not be cut. In fact, they should be increased. Having established the importance of behavior in health, it is critical that NIH place a stronger emphasis on behavioral and social science research.

We caution you not to deplete the mine of knowledge needed to keep this nation strong. It would indeed be shortsighted to create additional deficits for the next generation while attempting to solve the budget deficit.

Let us not leave to our children a deficit of scientists, a deficit of knowledge, and a deficit in basic research. They must have a strong foundation on which to build, stronger than just a balanced budget. We know you face difficult decisions in the days ahead. We urge for fiscal year 1987:

Rejection of the President's reductions in funding for health research;

Sufficient funds to support 6500 new and competing awards at NIH;

Additional funding for research training at NIH; and

Continued support for the health and behavior research.

The Federation thanks the subcommittee for their continued support for health research and for giving me this opportunity to share our views with you and the subcommittee.

Mr. NATCHER. Ms. Null, thank you very much. We appreciate your appearance.

[The statement of Ms. Null follows:]

FEDERATION OF BEHAVIORAL, PSYCHOLOGICAL AND COGNITIVE SCIENCES

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Cynthia H. Null, Ph.D.

Executive Director

Federation of Behavioral, Psychological and Cognitive Sciences

on behalf of

FEDERATION OF BEHAVIORAL, PSYCHOLOGICAL AND COGNITIVE SCIENCES

on the subject of

APPROPRIATIONS FOR

NATIONAL INSTITUTES OF HEALTH
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT

Fiscal Year 1987

before the

Subcommittee on Labor, Health and Human Services,
and Education

Committee on Appropriations

UNITED STATES HOUSE OF REPRESENTATIVES

The Honorable William H. Natcher, Chairman

May 7, 1986

American Educational Research Association • American Psychological Association • Cognitive Science Society • Human Factors Society •
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Society for Computers in Psychology • Society for Mathematical Psychology • Society for Psychophysiological Research •
Society for Research in Child Development • Society of Multivariate Experimental Psychology

Mr. Chairman and members of the Subcommittee, I am Dr. Cynthia H. Null, Executive Director of the Federation of Behavioral, Psychological and Cognitive Sciences. I am testifying today on behalf of the Federation, a coalition of 13 scientific societies with combined memberships of over 90,000. The Federation's interests include research on behavioral, psychological and cognitive processes and their physiological bases and its application to education, health and human development. Thank you for the opportunity to comment on the FY87 appropriations for the National Institutes of Health (NIH); the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); and the Office of Educational Research and Improvement (OERI) in the Department of Education.

It is important to the nation to maintain a strong Federal role in basic research even as the Congress is making major steps to reduce the Federal deficit. Research results cannot be bought on a short time scale. Neglecting basic research this year means fewer gains in subsequent years. We will not be able to remedy this deficit by increasing research spending at that later time. Good research requires attracting good people to work on important problems, training new researchers, obtaining basic results and working out their applications. None of this can be done quickly; the investment in ideas, methods and applications must be made now. That is why it is important for the government to maintain and enhance, wherever possible, its support for basic research.

National Institutes of Health

In discussing NIH, I will focus on behavioral science research at the National Institute of Aging (NIA) and at the National Institute of Child Health and Human Development (NICHD), although important behavioral science research is and must continue to be funded in other institutes as well. I will also discuss the health and behavior initiative at NIH. I will close with a discussion of the Administrations's proposed FY87 budget.

National Institute of Aging

In December 1985, Dr. Carl Eisdorfer discussed aging research at the Federation's Science and Public Policy Seminar. He dramatized the need for continuing such research by telling us: The fastest growing parts of the U.S. population, proportionately, are the oldest parts. In the 1970s alone, we have had a 40% increase in the over 75 population. The over 75 group, currently 11.5% of the population, is projected to be at least 20% by the year 2020. Projections are we will go from 1 1/2 million patients with dementia today to about 8 1/2 million patients with Alzheimer's and related dementias in the middle of the next century.

Given the blessing of longer lives, the important question becomes how healthy, active and independent our lives will be. Research being funded by NIA will play a major role in shaping the future of our nation's older population.

Research suggests that intellectual decline associated with aging can often be slowed by relatively simple training interventions. Age does not affect all senses similarly. Aging tends to dull the capacity to taste low concentrations of sweet, sour, salt and bitter; but the ability to taste moderate levels remains remarkably functional. Intervention strategies are being developed to help maintain older persons' appetites for food and thus their nutritional status. Although research repeatedly shows that people tend to become slower at most behavioral activities as they grow older, no age trend has been found in typing speeds where experience tends to compensate for loss of speed.

Behavioral geriatrics research seeks to understand how health behaviors and attitudes are acquired and their interaction with biological processes to promote or inhibit good health as people age. Research seeks to understand how the elderly utilize formal health care, comply with medical regimens, interpret symptoms and approach death. Research is needed to examine the potential of modifying social environments to enhance health and functioning.

For the elderly, nothing is more terrifying and life altering than Alzheimer's disease. Behavioral scientists are an important part of NIA's extensive research on Alzheimer's disease. Some areas of research include measurement of cognitive decline in Alzheimer's patients, development of early detection techniques and psychophysiological research into causes and treatment.

National Institute of Child Health and Human Development

Children are our future. Insuring that they are born healthy and have the opportunity to achieve their full potential is the mission of NICHD. Research sponsored by NICHD has improved our understanding of both normal and abnormal development.

Currently the field of cognitive development is enjoying a period of unprecedented growth. Research has revealed that babies respond to objects and events and to relationships between objects and events. Infants have an understanding of size and depth and are able to navigate through their environment by using their spatial knowledge. They also appear to be sensitive to emotional expression in others. Infants are aware of not only the existence of objects in a scene but their number. Such work holds promise for gaining an understanding of knowledge development.

During the past two decades much has been learned about the visual capacity of human infants. Research has provided detailed information on the development of visual acuity and on pattern, space and color perception. The methods used to develop this knowledge can also be used to diagnose visual pathology and evaluate early treatment.

At a Science and Public Policy Seminar sponsored by the Federation, Dr. Frances Horowitz discussed some of the important ongoing research on infants born at risk. Children who start life differently, behave differently. These different behaviors tend to elicit from parents different kinds of behaviors than normal infants elicit from their parents.

A greater understanding of normal development is essential for increasing our understanding of at risk and abnormal development. Understanding how the environment works and what makes a difference in the normal environment will give us our most powerful set of keys to ultimately helping at risk infants, according to Dr. Horowitz.

Health and Behavior

Mr. Chairman, we wish to commend the leadership you and this Subcommittee are taking in the important and promising research on health and behavior. Behavior has been linked to many health problems including cancer and heart disease. Health-impairing behaviors such as smoking, poor nutrition, heavy drinking, lack of exercise, failure to comply with treatment and delay in seeking medical care are all linked to serious disease. Stress has been linked to physical illness as well.

In recent years there has been a growing awareness that the failure of patients to adhere to prescribed medical regimens is probably the single greatest problem in bringing effective medical care to individual patients. Increasing evidence shows that prevention and behavioral medicine could significantly reduce morbidity and mortality from most leading causes of death. An important priority for research is the integration of behavioral and biomedical knowledge in a way that elucidate the mechanisms underlying the interrelationships between behavior and physiological processes.

NIH FY87 Appropriations

The Administration's FY87 budget request for NIH is $424 million below the FY86 appropriation level. Although we are sympathetic with deficit reduction efforts, we believe that the health of the people of this nation is too important to have research at NIH cut so drastically. We are, of course, concerned that the approximately 3% of the NIH funds which go to support behavioral and social science research should not be cut; in fact they should be increased. Having established the importance of behavior in health, it is critical that NIH place a stronger emphasis on behavioral and social science research.

We strongly support 6,500 new and competing awards at NIH. We are disappointed with the Administration's attempt to reduce the number of awards by setting the total number of grants at 18,000, of which 5,140 would be new awards. Such a reduction will seriously disrupt the Nation's long-term research capacity and dim our hopes of reaching national goals of a healthier American population.

NIH research training funds available in FY86 will fund approximately 9,950 trainees. The Administration's FY87 budget will fund only 9,250. We urge the Subcommittee to increase this proposed funding for research training and not to allow the number of trainees to be reduced.

Alcohol, Drug Abuse, and Mental Health Administration

The Institute of Medicine's report Research on Mental Illness and Addictive Disorders estimates that mental disorders, alcoholism and drug addictions profoundly affect 30 to 45 million people in the United States each year. These illnesses place a great strain on our nation. Another dramatic measure of the effect is the number of lives that are touched by those suffering from mental disorders and addictions. It is estimated that an additional 30 to 40 million people are affected by alcohol abuse alone--because a close family member is either alcoholic or has been killed or injured by an individual under the influence of alcohol. The Institute of Medicine estimates that the overall monetary impact of mental disorders and substance abuse in the United States is $185 billion per year.

Research efforts within the ADAMHA are and should continue to be directed beyond the understanding and treatment of specific mental disorders and addictions. We must understand the normal to understand the abnormal. The details of normal development are needed to prevent or treat childhood disorders. Studies of affective distortions of depressed individuals are meaningful only if we know more about emotional development in general. The perceptual anomalies of schizophrenics do not make much sense unless we fully understand the process of underlying perception.

Behavioral sciences are a central part of mental health research. There is a growing need to understand the etiology of mental illness through shared behavioral and biological information. The range of research includes attentional mechanisms and defects, correlates of personality competence, self-regulatory mechanisms, family processes, stress, and prosocial and aggressive behaviors. Let me give several specific examples.

Recent behavioral research on morphine addiction in animals has shown that the animals become conditioned to the place where they receive morphine. Relapse is more likely when the addiction and detoxification situations are different and the subject then returns to the addiction situation after detoxification. Withdrawal symptoms can be elicited without the animal receiving any morphine by exposing the animal to the situation where morphine was previously received. This may explain why street drug addicts who are detoxified in a prison or hospital relapse when they return to the street.

Experiments on the effect of alcohol and other drugs on developing fetuses have provided convincing evidence that behavioral symptoms, such as fetal alcohol syndrome, are because of drug effects rather than genetic or environmental causes. Research with animals who were prenatally exposed to sex hormones indicates that these animals have different, less appropriate repertoires of behavior later in development. These types of results have led to more conservative guidelines for behavior during pregnancy.

About 2 million children require immediate care due to severe mental disorders. An estimated 8 to 20 million have less urgent but real needs. The major mental health problems in childhood include developmental disorders, hyperkinetic behavioral and attention disorders, and psychotic disorders. Techniques have been developed to help in early diagnoses of emotional and attachment disturbances.

ADAMHA FY87 Appropriations

The present is marked by both expanding scientific opportunities and decreasing research support. The Administration has proposed decreasing ADAMHA research support to fund only 1,400 project awards, reducing new and competing awards from 550 for FY86 to about 450 in FY87. This reduction jeopardizes the health of research on mental health and drug and alcohol abuse.

Research training support at NIMH has declined dramatically in the last decade. The number of trainees has dropped from 1,352 in FY80 to about 816 in FY86. The Administration's budget proposes a further reduction to 751 for FY87. Also proposed are training grant reductions at NIDA (from 77 in FY86 to 68 in FY87) and at NIAAA (from 66 to 63). The most recent edition of the Institute of Medicine's Personnel Needs and Training for Biomedical and Behavioral Research continues to advocate increased Federal support for behavioral science research training.

We are also concerned about the large reductions in the small grants program at NIMH. Recently NIMH has been able to fund about 70 small grants per year; the plan for FY87 calls for only 22 awards. This program has been a very important source of funding for new investigators. Its near elimination will have dramatic negative consequences for future research progress.

Office of Educational Research and Improvement

It is crucial to our nation's future that we provide excellent education for our young people, but providing this excellence is proving increasingly difficult with traditional instruction. Research on education is now accepted as a necessity.

Largely because of the influence of the former National Institute of Education (NIE), studies of reading are producing a clearer picture of how young children learn letter patterns and associated sounds in English. Acquiring sensitivity to the sounds and rhythms of words can be bolstered by home activities. Parents can play an important role by reading aloud to their children. The speed and efficiency with which children achieve word recognition is a major determinant of reading comprehension. So that meaning can be given to a written passage, word decoding must become automatic. Children bring more prior knowledge and complex mental processes to reading than was originally believed. Such research results are beginning to influence reading instruction.

New information about the sources of difficulty in understanding mathematical, scientific and technical concepts provides a basis for development of educational materials and methods for reaching a broader group of students. In addition, research to identify factors contributing to the relatively low levels of participation in mathematics and science courses by women and members of minority groups is underway and is suggesting ways to encourage increased participation.

By applying research like this, we could provide effective materials for teachers to help students learn reliably and efficiently. We believe basic research of the kind described can help our nation provide improved education, even though it may continue to be difficult to attract and retain enough good teachers. These comments are especially true for mathematics and science education, where good teachers are especially hard to recruit and where the research described may have its earliest successes.

The examples given, however, are limited to a few subject areas. We will not revolutionize the school curricula tomorrow. Continued research is needed to understand mechanisms of learning and reasoning in more subject areas and to learn how to apply our understanding to produce better practical instruction.

OERI FY87 Appropriations

The Administration's request of $70.2 million for OERI in FY87 is the minimum amount commensurate with the need for research in education and with the ability of the educational research community. Fiscal resources for the Department of Education increased from approximately $6.1 billion in 1973 to $17.1 billion in 1984, an increase of 22% in constant dollars. During the same period NIE resources fell 76%. As the funds decreased, the proportion of NIE support going to Congressionally mandated research centers and regional laboratories increased to a point where NIE could not sponsor field initiated studies.

We were pleased to see OERI announce a small field initiated research program for FY86 and propose a larger effort in the FY87 budget. The OERI needs resources to respond to investigator-initiated research proposals. Because there has been barely enough funding to support prior commitments to the research centers and regional laboratories, there has essentially been no resources to support the independent researcher with a novel idea or the innovative collaboration of a group of researchers from different disciplines. While excellent work is done at some of the research centers and regional laboratories, the lack of uncommited resources means no ability to respond to fresh new ideas from unforeseen sources. It also limits the ability to support and encourage interdisciplinary research (e.g., between cognitive psychologists, educators and subject-matter experts). Finally, it limits the pool of research talent the OERI can tap.

Conclusions

We know you face difficult budget decisions in the days ahead, but we caution you not to deplete the mine of knowledge needed to keep this nation strong. We share with you a strong concern for consistency of funding for research by the Federal government. It is important to the training of future generations of scientists, the treatment and prevention of illness, the birth of healthy and wanted babies, increased functioning of the elderly, the improvement of the mental health of the people of this nation, and the education of our children. We are grateful for the continued support of this Subcommittee. We urge for FY87:

- rejection of the President's research funding reductions at NIH and ADAMHA,
- sufficient funds to support 6,500 new and competing awards at NIH,
- sufficient funds to support about 600 new and competing awards at ADAMHA,
- additional funding for research training for NIH and ADAMHA,
- continued support for the health and behavior research,
- restoration of the small grants program at NIMH, and
- funding OERI at least at the level of the Administration's FY87 budget.

The Federation thanks the Subcommittee for the opportunity to share our views with you. Please do not hesitate to call on the Federation staff if we can be of further assistance during your deliberations.

WEDNESDAY, MAY 7, 1986.

NICHD

WITNESS

DR. KATHERINE CHRISTOFFEL, DIVISION OF GENERAL AND EMERGENCY PEDIATRICS, CHILDREN'S MEMORIAL HOSPITAL, CHICAGO, ILLINOIS

Mr. NATCHER. Our last witness is Dr. Katherine Christoffel. Come on around, Dr. Christoffel.

Dr. CHRISTOFFEL. Thank you, Mr. Chairman.

My name is Katherine Christoffel, and I am the Director of the Nutritional Evaluation Service, Children's Memorial Hospital, Committee on Nutrition, the Illinois Chapter of the American Academy of Pediatrics.

Thank you for the opportunity to speak to you concerning the need for establishing a National Severe Undernutrition Surveillance Program. I understand that consideration of new programs is not the rule these days, and that your willingness to consider this one reflects recognition of its extreme importance.

In the interest of time, I will focus my comments on children. However, many of the points I will make pertain to adults as well.

In the last few years, epidemic famine in Africa has brought all of us to renewed awareness of the devastating effects of malnutrition, particularly when it involves mothers and children.

Even before this, it has been known for decades that malnutrition is a contributing factor in many, if not most, childhood deaths among impoverished people in underdeveloped countries. We know that in our own country, WIC, the Special Supplemental Nutrition Program for Women, Infants and Children, is effective in reducing low birthweight births.

Despite this knowledge, the possibility that malnutrition contributes more broadly to morbidity and mortality in this country has never been systematically addressed. I believe there is no cogent reason to tolerate ignorance of the extent of malnutrition in the U.S., particularly as concerns mothers and children.

Rather, there is ample reason to undertake phased implementation of a malnutrition surveillance system designed to provide the information that is needed. The facts that lead to this conclusion may be summarized as follows.

First, primary malnutrition—malnutrition due to lack of adequate food—does exist in this country. My testimony last year before the House Select Committee on Hunger, as well as the testimony of others, made it clear that physicians around the country too often see children who require treatment for severe malnutrition due to inadequate food. Most of these children become hospitalized, usually at government expense.

Copies of the article we have published concerning 16 children treated at the hospital where I work have been provided to you.

It is likely that the brain development of these children and others like them is irreversibly damaged.

Second, there is reason for grave concern that current government policies have contributed to an increased prevalence of childhood malnutrition.

In its report last May entitled "Children in Poverty", the House Committee on Ways and Means documented in detail the startling and continued rise in family poverty during the 1980s and the simultaneous fall in the real value of public assistance provided.

As best we can ascertain, most severely malnourished children in the U.S. are poor. Most of those children we reported in our article were poor.

Physicians in Massachusetts, Texas and other states have made the same observation. We live in a time when poverty among children continues to rise beyond current record levels. Already, 1 of every 5 U.S. children lives in poverty and approximately half of all poor U.S. citizens are children.

We know that existing food does not reach these children as routinely as it should. Yet the government is paying farmers to destroy milk herds to reduce milk production. Something is amiss.

It is poor business practice, and worse public health practice, to fail to ascertain the effects of public policies concerning social services, food production and food distribution on the growth and health of our most precious resource, the nation's children.

The third piece of evidence leading to the conclusion that severe malnutrition surveillance is needed is that the current nutrition surveillance system is not able to detect many cases of severe malnutrition.

As Mr. Dennis Tolsma, Head of the Center for Health Promotion and Education, has testified here previously, the current surveillance system relies on measurements taken in the course of regular health care in public clinic settings. The severely malnourished children seen in pediatric hospitals usually reach their severe state in part because they do not get any routine health care.

Yet because there is no system to gather and investigate reports of such children, we know neither how many children suffer from starvation disease, nor exactly why. To develop a strategy to eradicate this problem, we must learn how children come to starve for want of food in the richest country in the world.

Provision for increased surveillance by The Centers for Disease Control would reflect recognition that severe malnutrition, like polio, is a preventable medical problem with serious and potentially irreversible consequences. Today, malnutrition is much more common than polio.

The merits of the proposal for phased implementation of a severe malnutrition surveillance system are reinforced by support, already expressed at this relatively early stage of the proposal's development, by The Association of State and Territorial Health Officials, The National Perinatal Association, The Association of State and Territorial Public Health Nutrition Directors, Dr. Jean Mayer, the President of Tufts University, pediatricians across the country who care for malnourished children, and local organizations such as The Illinois Hunger Action Coalition, and The Community Renewal Society of Chicago.

Questions have been raised about whether we can arrive at a workable definition of malnutrition. Several factors make it clear that this is not a major problem. Louisiana has had a state malnutrition reporting system.

CDC is now conducting a pilot study monitoring severe malnutrition at Grady Hospital in Atlanta. Pediatricians and dieticians around the country are diagnosing hunger disease.

I have no doubt that all of those involved in these and similar efforts would be able to work with any clear definition that might be arrived at by a panel of appropriate professionals. As with other conditions, such as AIDS, definition should be expected to evolve with our understanding.

I urge you most strongly to approve funding of phased implementation of a nationwide severe malnutrition surveillance system.

The first phase would involve expansion of current pilot programs to include statewide surveillance in several states, to permit development of technical details. Within a year, expansion to a nationwide system should be undertaken.

We can ill afford not to know which children, which mothers, which potentially productive citizens in our society are being damaged by malnutrition, a preventable disease for which the treatment is food.

Thank you for your attention and consideration.

Mr. NATCHER. Thank you very much, Doctor.

[The statement of Dr. Katherine Christoffel, and a letter from Congressman Mickey Leland and Congresswoman Marge Roukema follow:]

There is Urgent Need for a National Severe Malnutrition Surveillance System

Testimony Before
The
Subcommittee on Labor, Health and
Human Services and Education Appropriations

Thursday, April 24, 1986, 3:30 P.M.
Room 2358 (3rd floor),
Rayburn House Office Building

Katherine Kaufer Christoffel, M.D., M.P.H.

Associate Professor, Pediatric and
Community Health & Preventive Medicine
Northwestern University Medical School, Chicago, Il.

Director, Nutrition Evaluation Service
Children's Memorial Hospital, Chicago, Il.

Chairman, Committee on Nutrition
Illinois Chapter, American Academy of Pediatrics

Chairman Natcher and Committee Members,

Thank you for the opportunity to speak to you concerning the need for establishing a National Severe Undernutrition Surveillance Program. I understand that consideration of new programs is not the rule these days, and that your willingness to consider this one reflects recognition of its extreme importance. In the interests of time, I will focus my comments on children. However, many of the points I will make pertain to adults as well.

In the last few years, epidemic famine in Africa has brought all of us to renewed awareness of the devastating effects of malnutrition, particularly when it involves mothers and children. Even before this, it has been known for decades that malnutrition is a contributing factor in many--if not most--childhood deaths among impoverished people in underdeveloped countries. We know that in our own country, WIC, the Special Supplemental Nutrition Program for Women, Infants and Children, is effective in reducing low birthweight births.

Despite this knowledge, the possibility that malnutrition contributes more broadly to morbidity and mortality in this country has never been systematically addressed. I am here to argue that there is no reason to tolerate ignorance about the extent of malnutrition in the U.S., particularly as concerns mothers and children. Rather, there is ample reason to undertake phased implementation of a malnutrition surveillance system designed to provide the information that is needed. The facts that lead to this conclusion may be summarized as follows.

First, primary malnutrition--malnutrition due to lack of adequate food--does exist in this country. Testimony by myself and others last year before the House Select Committee on Hunger made it clear that physicians around the country too often see children who require treatment for severe malnutrition due to inadequate food. Most of these children become hospitalized, usually at government expense. (Copies of the article we have published concerning 16 children treated at the hospital where I work have been provided to you.) It is likely that the brain development of these children and others like them is irreversibly damaged.

Second, there is reason for grave concern that an unintended effect of current government policies is increased prevalence of childhood malnutrition. As best we can ascertain, most severely malnourished children in the U.S. are poor. Most of those children we reported in our article were poor. Physicians in Massachusetts, Texas and other states have made the same observation. We live in a time when poverty among children continues to rise beyond current record levels. Already, 1 of every 5 U.S. children lives in poverty and approximately half of all poor U.S. citizens are children. We also live in a time when funded services to poor families are being progressively reduced. Existing food does not reach these families as routinely as it should. Yet the government is paying farmers to destroy milk herds to reduce milk production. Something is amiss. It would be shoddy business practice and worse public health practice to fail to ascertain the effects of public policies concerning social services and food production and distribution on the growth and health of our most precious resource, the nation's children.

The third piece of evidence leading to the conclusion that severe malnutrition surveillance is needed is that the current nutrition surveillance system is not able to detect many cases of severe malnutrition. As Mr. Dennis Tolsma, Head of the Center for Health Promotion and Education has testified here previously, the current surveillance system relies on measurements taken in the course of regular health care in public clinic settings. The severely malnourished children seen in pediatric hospitals usually reach their severe state in part because they do not get any routine health care. Yet because there is no system to gather and investigate reports of such children, we do not know how many children suffer from starvation disease, nor exactly why. Provision for increased surveillance by The Centers for Disease Control would reflect recognition that severe malnutrition, like polio, is a preventable medical problem with serious and potentially irreversible consequences. Malnutrition, however, is undoubtedly much more common.

The merits of the proposal for phased implementation of a severe malnutrition surveillance system are reinforced by support, already expressed at this relatively early stage of the proposal's development, by The Association of State and Territorial Health Officials, The National Perinatal Association, The Association of State and Territorial Public Health Nutrition Directors, The Community Renewal Society of Chicago, The Illinois Hunger Action Coalition, the President of Tufts University (Dr. Jean Mayer) and pediatricians across the country who care for malnourished children.

Questions have been raised about whether a workable definition of malnutrition can be arrived at. Several factors make it clear that this is not a major problem. There already exists a state malnutrition reporting system in Louisiana. Pilot studies of malnutrition are already underway at CDC. Pediatricians and dieticians around the country are diagnosing hunger disease. I have no doubt that all of those involved in these and similar efforts would all be happy to work with any clear definition that might be arrived at by a panel of appropriate professionals. As with other conditions, such as AIDS, definitions should be expected to evolve with our understanding.

I urge you most strongly to approve funding of phased implementation of a nationwide severe malnutrition surveillance system. The first phase would involve expansion of pilot programs to more states on a voluntary basis, to permit development of technical details. Within a year, expansion to a nationwide system should be undertaken. We can ill afford not to know which children, which mothers, which potentially productive citizens are being damaged by malnutrition, a preventable disease for which the treatment is just food.

Thank you for your consideration.

[illegible] TEXAS
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TONY P. HALL, OHIO
BOB TRAXLER, MICHIGAN
LEON E. PANETTA, CALIFORNIA
THOMAS A. DASCHLE, SOUTH DAKOTA
VIC FAZIO, CALIFORNIA
SAM GEJDENSON, CONNECTICUT
PETER H. KOSTMAYER, PENNSYLVANIA
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U.S. House of Representatives
SELECT COMMITTEE ON HUNGER
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DOUG BEREUTER, NEBRASKA

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May 13, 1986

The Honorable William H. Natcher
Chairman
Subcommittee on Labor-HHS-Education
House Committee on Appropriations
2358 Rayburn House Office Building
Washington, D.C. 20515

Dear Bill:

We appreciate your arranging to hear testimony from Katherine Christoffel, M.D., before your Subcommittee on Thursday, May 7. Her testimony brought to light the urgent need for a national surveillance system to document cases of severe undernutrition among children. As you recall, we participated in a colloquy on the Floor last year on this important matter.

Since our last discussion, Centers for Disease Control (CDC) officials have informed us the Division of Nutrition is conducting a small pilot project at Grady Hospital in Atlanta to establish a methodology for reporting cases of severe undernutrition at hospitals. CDC has stated, upon completion of this pilot project, it will be necessary to conduct larger demonstration projects to determine the design of a nationwide surveillance system.

Based on this information from CDC, we ask that the Committee Report to accompany the Labor-HHS-Education FY '87 Appropriations bill include language on this issue. Specifically, we would like to see language urging CDC to conduct two statewide pilot projects for the surveillance of severe undernutrition among children, to commence within twelve months of the date of the enactment of the bill. As you are aware, this would need no new authorization because it is an expansion of CDC's current nutrition surveillance activities under chronic and environmental disease prevention.

It has been a pleasure working with you on the Subcommittee's investigation of this issue. We look forward to continued coordination of such efforts in the future.

Sincerely,

Mickey Leland
Chairman

Marge Roukema
Ranking Minority Member

CONCLUDING REMARKS

Mr. **Natcher.** This concludes the hearings for outside witnesses on the bill for Fiscal Year 1987.

These hearings were held on February 24 and from April 28 to May 7. During this time we have heard from more than 287 witnesses. We have also received many written statements from others, which will be printed in the record. On behalf of the subcommittee, I want to thank our staff assistant, Ms. Bettilou Taylor, for the excellent manner in which she has scheduled all of these witnesses to appear.

It requires skill, patience, and considerable hard work to bring this about. I think we have had better hearings this year than at any time since I have been Chairman and at any time since I have been a member of this subcommittee.

Ms. Taylor, we want to thank you for an excellent job and for your patience and skill in bringing this about. You have been organizing these hearings single handed now for 9 years and they are getting better every year.

We also want to thank the other staff members, Henry Neil, Fred Pflinger, Bob Knisely, Mike Stephens, and Chris Singer who have worked with us so diligently on the bill, and we expect that with their continued assistance we will be able to bring out a good bill, one that the President will sign and one that will provide additional funds for the programs that mean so much to the people.

We believe on this subcommittee that the bill that appropriates the money for the Department of Labor, Department of Health and Human Service, and the Department of Education, is the appropriations bill that is much closer to the hearts of the people in this country than any other appropriations bill that we have.

As all the members of this subcommittee know, we have 13 appropriations bills. We take the President's budget and divide it into 13 parts, among 13 subcommittees not necessarily equal moneywise. And each subcommittee proceeds to hold hearings on its section of the budget.

This has been the procedure this year, the same as it has been in the past for many, many years.

Again, on behalf of the subcommittee, Ms. Taylor, I want to thank you for an excellent performance and for your assistance during the hearings with the outside witnesses.

PREPARED STATEMENTS

We have a number of statements which have been submitted to us by interested individuals and organizations as well as from several Members of Congress. These statements will be placed in the record. In accordance with our usual custom, we will hold the hearing record open for several days for the purpose of permitting additional statements, which we understand are on the way, but which have not yet been received. They will also be included in our hearing record.

The Committee will stand in adjournment subject to call of the Chair.

[The following information was submitted for the record:]

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May 12, 1986

The Honorable William H. Natcher
Chairman
Subcommittee on Labor-Health and Human Services-
Education
Committee on Appropriatons
2358 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Natcher:

On behalf of the Committee on Education and Labor, I would like to submit the enclosed testimony which is submitted in support of the Office of Federal Contract Compliance Program's (OFCCP) fiscal year 1987 appropriatons. As this testimony provides, the Committee is recommending that the OFCCP be funded at $48.5 million and at 930 Full-Time-Equivalents (FTEs) for the next fiscal year. This amount constitutes an increase of $2.6 million and 20 FTEs over the President's proposal which we view as inadequate to serve the needs of those who are intended to be protected by Executive Order 11246.

We are not unmindful of the fiscal constraints in which we find ourselves in this year of the Gramm-Rudman-Hollings Deficit Reduction Act. It is our view, however, that OFCCP, which has suffered a substantial decrease in funding and staff resources in recent years, must be adequately funded if it is to effectuate its mandate.

I appreciate your consideration in this matter.

Sincerely,

Augustus F. Hawkins
Chairman

Enclosure

MAJORITY MEMBERS:
AUGUSTUS F. HAWKINS, CALIFORNIA,
Chairman

WILLIAM D. FORD, MICHIGAN
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STATEMENT OF THE HONORABLE AUGUSTUS F. HAWKINS
CHAIRMAN, COMMITTEE ON EDUCATION AND LABOR
BEFORE THE SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

May 12, 1986

Chairman Natcher and Members of the Subcommittee:

Thank you for the opportunity to testify before you on behalf of the Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, and its fiscal year 1987 appropriations.

As you know, the OFCCP is responsible for enforcing Executive Order 11246 as amended, the affirmative action provisions of the Rehabilitation Act of 1973, as amended, and related provisions of 38 Section 2012, the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended. The Executive Order prohibits discrimination by federal contractors on the basis of race, color, sex, religion, or national origin and requires that contractors take affirmative action where necessary to remedy the effects of discrimination. Section 503 of the Rehabilitation Act and 38 Section 2012 contain similar provisions for handicapped persons, disabled veterans, and Vietnam Era veterans. Responsibility for enforcement of the Executive Order and the above statutes lies with the Department of Labor, Office of Federal Contract Compliance Programs (OFCCP), and is accomplished by compliance review of contractor establishments and by complaint investigations. Acts of non-compliance are remedied by conciliation or, if this method fails, by imposition of the sanctions provided by law.

The OFCCP has the tremendous task of enforcing Executive Order 11246 and the above statutes, which cover approximately 123,000 prime non-construction contractors and 100,000 construction establishments. One-third of the civilian labor force or over 23 million employees are protected by the Executive Order. Over $167 billion in direct federal contracts fall within the OFCCP's jurisdiction. In fiscal year 1985, OFCCP reportedly performed 5,217 compliance reviews and 1,003 complaint investigations. In fiscal year 1986, OFCCP is projected to conduct 4,945 compliance reviews and 960 complaint investigations, and in fiscal year 1987, it is estimated that 5,225 compliance reviews and 995 complaint investigations will be completed. While the past and present compliance activity is laudable, given the OFCCP's substantially limited resources, this effort reaches less than five percent of the number of federal contractors covered by the Executive Order. We suggest that additional funds must be appropriated so that OFCCP can extend its reach and monitor more companies' equal employment opportunity and affirmative action programs.

Susan R. Meisinger, Deputy Under Secretary of Labor for Employment Standards, testified before you on February 27, 1986, regarding the President's budget request and its impact on the OFCCP's enforcement program. I am deeply concerned that the request for fiscal year 1987 of $45.9 million and 910

Full-Time Equivalents (FTEs) will not be sufficient for the OFCCP to effectively enforce its obligations, particularly in light of previous reductions in staffing and resources which have severely diminished its capacity to enforce the law, and in view of the projected increase in compliance activity which the OFCCP intends to undertake. I am therefore recommending that an additional $2.6 million and 20 FTEs be appropriated to the OFCCP over the amount requested by the Administration.

The OFCCP has experienced substantial reductions in staffing since fiscal year 1984. In that year, OFCCP's budget was $43.9 million with 979 positions; in 1985, $46.6 million (before reprogramming of $2.0 million for the benefit of the Federal Employees Compensation Act (FECA) Level II computer system; $44.6 after reprogramming) and 964 or 958 FTEs; in 1986, pursuant to P.L. 99-177, the Balanced Budget and Emergency Deficit Control Act (Gramm-Rudman-Hollings) OFCCP will face a reduction $2.0 million and 58 FTEs, which will leave it with only $43.6 million and 900 FTEs to perform the important enforcement functions of the agency. Thus, in fiscal year 1986, OFCCP will lose 9.3% of its FTEs when compared with FY 1985. For an agency the size of OFCCP, this reduction in staffing will adversely affect its ability to conduct adequate complaint investigations, compliance reviews as well as effective monitoring of conciliation agreements.

It has also come to our attention that OFCCP will be forced to furlough its staff for approximately six days in fiscal year 1986, in order to absorb its share of the reductions imposed upon the Employment Standards Administration by Gramm-Rudman-Hollings (Public Law 99-177). Moreover, OFCCP will impose a hiring freeze, curtail staff training and travel expenditures in order to effect the required reductions in funding. These reductions in resources and staff time will only serve to enhance the frustration of OFCCP's civil rights enforcement effort.

While the President's proposal to increase OFCCP's budget from the FY 1986 appropriations level of $43.6 million and 900 FTEs to $45.9 million and 910 FTEs reflects a recognition that the work of the OFCCP is important and must be adequately funded, the proposal does not begin to compensate for the losses in funding and staff which OFCCP has sustained since FY 1984. Given the importance of increasing the number of enforcement staff and resources to accomplish the objectives of this agency, the Committee on Education and Labor voted in March of this year to recommend that OFCCP be funded at $48.5 million and 930 FTEs for fiscal year 1987. The additional amount constitutes only $1.9 millicn over the 1985 level and provides 28 fewer FTEs than OFCCP had in that year.

Neither the Members of the Committee on Education and Labor nor I, as its Chairman, make this recommendation without due regard for the fiscal constraints facing the Congress this year. It is our view however, that the OFCCP, which enforces Executive Order 11246, proven by the Department of Labor and by experts in the private sector to be one of the most effective civil rights enforcement tools, must be able to effectuate its mandate. By continuing to suffer repeated reductions in staffing and resources, however, it will not be able to do so.

In accordance with the views of the Department of Labor's Office of Inspector General, which recently conducted an audit of the OFCCP's operations, we recommend that the increases in funding and FTEs be used for additional non-supervisory enforcement caseworkers (Employment Opportunity Specialists) in the field offices. Moreover, whenever managerial and supervisory positions become available in the national and regional offices, these FTE slots should be transferred to the area and field offices as enforcement caseworker positions. In this way, OFCCP will be able to reduce the excess overhead identified in the Inspector General's report by reducing the percentage of managerial and supervisory staff in the national and regional offices, and will be able to increase the number of workers performing compliance functions.

The additional funding for OFCCP should also be used to enhance the agency's Automated Data Processing and micro computer systems and to provide much-needed training and on-site travel monies so that enforcement staff may be able to effectively view first-hand the equal employment opportunity records of the contractors subject to the Executive Order program.

We are not unmindful of the organizational problems currently facing the OFCCP, which were highlighted in the report of the Office of the Inspector General. Among the problems noted in this report are: excess overhead, large numbers of staff at high grades, and an inefficient field structure. Moreover, the Inspector General's report points out that OFCCP's enforcement procedures prevent complete, timely and economical enforcement: the regulations and procedures permit identification of only a small portion of the construction contractor universe, the contractor selection process and documentation of contractors selected is in need of improvement, and there is inadequate tracking of progress reports which contractors, who are identified as in violation of the law, submit to the agency. Lastly, the Inspector General's audit found that there is no system in place to evaluate program results. We strongly recommend that OFCCP, its Director, Joseph N. Cooper, and Deputy Under Secretary Meisinger, undertake a serious effort to address these problems and to effect the changes recommended by the Inspector General. Moreover, the appropriations which we are requesting for the OFCCP should be made with the condition that the recommendations made by the Department's Office of Inspector General be implemented as quickly as possible.

I have attached to this testimony proposed report language concerning OFCCP's appropriations and I request that the Appropriations Committee seriously consider this language in its deliberations regarding OFCCP. Thank you for the opportunity to testify before you today.

Attachment

Recommended Report Language for OFCCP's Fiscal Year 1987 Appropriations

For necessary expenses for the Office of Federal Contract Compliance Programs (OFCCP), it is recommended that the important work of this enforcement agency be funded at a level of no less than $48.5 million and 930 full-time-equivalent (FTE) positions for fiscal year 1987. The additional amount constitutes $4.9 million over the FY 1986 level after the reductions imposed by P.L. 99-177, and provides thirty additional FTEs over the previous year's level. The increase in funding will be used for the wages and salaries of additional non-supervisory enforcement caseworkers (Equal Opportunity Specialists) to enhance the agency's compliance activities, for much-needed training and on-site travel, and for increased funds to support the agency's automated data processing and micro computer systems.

In addition, whenever managerial and supervisory positions become available in the headquarters and regional offices, these FTE positions should be converted to Equal Opportunity Specialist (EOS) positions and transferred to area and field offices. This is consistent with a report by the Department of Labor, Office of Inspector General, which noted problems concerning excess overhead, large numbers of staff at high grades and an inefficient field structure at OFCCP.

It is the desire of the Members of the Committee that funds appropriated for the OFCCP be utilized solely for this program activity within the Employment Standards Administration's account in order that this enforcement agency may have sufficient resources to effectively monitor federal contractors' equal employment opportunity and affirmative action programs.

ROBERT L. LIVINGSTON
1st District, Louisiana

APPROPRIATIONS COMMITTEE
SUBCOMMITTEE
DEFENSE

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE

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Congress of the United States
House of Representatives
Washington, DC 20515

May 19, 1986

The Honorable William H. Natcher
U.S. House of Representatives
2333 Rayburn HOB
Washington, D.C. 20515

Dear Chairman Natcher:

I am writing to express my high regard and strong support for the programs in civic education conducted by the Close Up Foundation and to request your support once again to continue the Allen J. Ellender Fellowship Program.

I have had the pleasure of meeting with many Close Up groups. One thing I always try to impress on these students is how much the decisions we make today will affect their future. It is with this same sense of concern for the future that I strongly urge the continued funding of the Allen J. Ellender Fellowship Program.

As a fellow member of the Appropriations Committee, I am well aware of the constraints under which we operate today, particularly when we face such high deficits. I think all of us would agree, that in reviewing the many programs before us, we should remain with those programs which are proven successes and which produce the maximum return on a minimum Federal investment. The Close Up Foundation, on examination of its record, certainly stands out as a program which has multiplied our modest investment many times over.

Since the Allen J. Ellender Fellowship Program was instituted in 1972, Close Up has been unceasing in their efforts to build on this base of support so that the maximum number of young people could be reached. I offer some examples of this impressive "multiplier effect".

1--Each year, Close up has substantially increased the number of students and teachers coming to Washington, D.C., and now its alumni number more than 180,000.

2--Each year, Close Up has significantly increased the ratio of private sector dollars to Congressional support. For example, the 1974 ratio was 4 to 1, while the 1986 ratio is more than 12 to 1.

3--Each year, Close Up has developed new programs and activities to encourage participation at all levels and among all age groups. This year, nearly 90 state or local programs were conducted around the country and involved both students and older Americans.

4--Each year, Close Up has produced educational resources to complement the Washington program and to provide current material for classroom use. These include award winning academic publications and public affairs telecasts.

In addition to these benefits, there are countless stories of young people who, because of their Close Up experience, are beginning their adult life invigorated by the challenges of a participatory democracy and excited by the knowledge that they can make a difference.

Thank you for your continued support of this valuable program and and your consideration of this request.

Sincerely,

ROBERT L. LIVINGSTON
Member of Congress

RLL/pc

LINDY (MRS. HALE) BOGGS, M.C.
2D DISTRICT, LOUISIANA
COMMITTEES
APPROPRIATIONS
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES
(CHAIR, TASK FORCE ON CRISIS INTERVENTION)
PEG KAVALJIAN
ADMINISTRATIVE ASSISTANT

Congreſs of the United States
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Washington, DC 20515

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May 19, 1986

Honorable William Natcher
Chairman
Subcommittee on Labor, HHS, & Education
House Committee on Appropriations
2358 Rayburn Building
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to express, as I have so many times before, my continuing support and enthusiasm for the work of the Close-Up Foundation and the benefits that accrue through the Allen J. Ellender Fellowship Program. Since the first Ellender fellowships were awarded in 1972, I have watched the effect they have had for students and teachers in Louisiana and throughout the Nation.

I have watched with a very keen interest because of the special significance the fellowships have for me as a Louisianan. As you know, the fellowship program takes its name from the late Senator Ellender of Louisiana. Senator Ellender and my late husband, Hale, were two early and ardent supporters of Close-Up's work in citizenship education. They both strongly believed in the importance of helping young people from every background and economic status about their role as citizens.

I, too, believe that it is vitally important for young people to understand the rights and responsibilities of citizenship, and it has been exciting for me to watch the growth of the Close-Up Program as it accomplishes these educational goals with more and more students and teachers. The Allen J. Ellender Fellowship Program is at the core of Close-Up's growth.

By providing money for low-income students and their teachers, the Ellender fellowships encourage expansion of the Close-Up Foundation's work on several levels. Students and teachers are motivated to generate their own funds when Ellender "seed money" is available; corporations and philanthropic organizations have an incentive to provide matching funds when they know that Congress supports the work of Close-Up; and the staff of the Close-Up Foundation is inspired to develop new and improved programs when they see the community involvement and coopertaion generated through the Ellender fellowships.

Honorable William Natcher
Page Two
May 19, 1986

Another aspect of the Ellender Program that deserves special attention is the educational benefits it provides for teachers. Teachers are key players in helping students understand citizenship and our democracy. It is teachers who must prepare the students for their Washington trip; who must keep the learning process going when the students return home; and who must serve as role models in the community.

The Close-Up Foundation, since its beginning, has recognized what a critical part teachers play and has developed a separate program for them. The Close-Up Teacher Program is designed to enhance skills, to explore current issues and to renew energy. For many teachers, the trip to Washington may be their first so it is rewarding for them to see the Washington perspective and to experience the democratic process firsthand. For those who are repeat Washingotn visitors, the Teacher Program allows them the opportunity to use the many resources available in the area. They continue to report that it is a unique in-service opportunity and an invaluable supplement to their own training as educators.

Ellender fellowship dollars are dollars well spent. The growth of the program and the continuing positive feedback from participants are important indicators of Close-Up's success. Watching the program over the years has only strengthened my belief in its effectiveness. I hope the Members of the Subcommittee will maintain their strong support of the Allen J. Ellender Fellowship Program.

With all good wishes.

Sincerely,

Lindy

Lindy (Mrs. Hale) Boggs, M.C.

LB:wc
Enclosure

April 1986

CLOSE UP AT A GLANCE

REFERENCE INFORMATION
ON THE CLOSE UP FOUNDATION

HISTORY

1. CLOSE UP was founded in 1970.
2. First program was conducted in 1971.
3. Initial passage of Allen J. Ellender Fellowship Program was October 1972.
4. First Allen J. Ellender recipients participated in January 1973.

CURRENT YEAR SCOPE
(1985/86 Program Year)

1. 1985/86 marks the 16th Program Year.
2. Approximate Number of Participants To Date: 180,000
3. Estimated Number of Participants 1985/86: 23,000
4. Total Number of Participating High Schools 1985/86: 2,800
5. Number of Communities 1985/86: 75 plus Hearing-Impaired, Visually Impaired, Department of Defense Dependents Schools.
6. CLOSE UP includes all 50 states, the Commonwealth of Puerto Rico, District of Columbia, and the American Territories.
7. Tuition: 1985/86 $530 (excluding transportation)
8. Local Program Participation: 75,000 students and teachers annually (no utilization of Allen J. Ellender Funds).
9. CLOSE UP's televised programs on the Cable Satellite Public Affairs Network (C-SPAN) are wired to reach approximately 3,000 high schools and a home viewing audience of 24 million homes.

ANTICIPATED FELLOWSHIP SCOPE
(FY86 Appropriations Bill - 1986/87 Program Year)

1. Projected Operating Budget for 1986/87 Program Year: Approximately $22 million.

2. Allen J. Ellender Appropriation for 1986/87 Program Year:

   $1,700,000 (FY86 Labor-HHS Bill PL 99-178) The 4.3% sequestration effected by Gramm-Rudman-Hollings will result in an actual appropriation level of $1,623,000.

3. Total Close Up Foundation Fellowship Obligation for 1986/87 Program Year:

   Approximately $4,500,000 (includes Allen J. Ellender Fellowships and community corporate and philanthropic matching fellowships). This figure does not include some $2.3 million in merit fellowship support from civic organizations, small businesses, school boards and individuals.

4. Estimated Number of Participating High Schools: 3,000

5. Estimated Number of Participants: 24,000

ANTICIPATED FELLOWSHIP SCOPE
(FY87 - 1987/88 Program Year)

1. Projected Operating Budget for 1987/88 Program Year: Approximately $24 million.

2. Allen J. Ellender Authorization for 1987/88 Program Year (FY87) PL 98-312: $2,000,000.

3. Total Close Up Foundation Fellowship Obligation for 1987/88 Program Year:

   Approximately $4,800,000 (includes Allen J. Ellender Fellowships and community corporate and philanthropic matching fellowships). Figure does not include some $2.9 million in anticipated merit fellowship support from civic organizations, small businesses, school boards and individuals.

4. Estimated Number of Participating High Schools: 3,200

5. Estimated Number of Participants: 25,000

CLOSE UP AT A GLANCE
April 1986
Page Three

SUMMARY OF
CURRENT ALLEN J. ELLENDER AUTHORIZATION AND APPROPRIATIONS

Fiscal Year	Program Year	Authorization	Appropriation
1984	1984/85	$1,500,000	$1,500,000
1985	1985/86	$1,500,000	$1,500,000
1986	1986/87	$2,000,000	$1,700,000 ($1,623,000)*
1987	1987/88	$2,000,000	-
1988	1988/89	$2,500,000	-
1989	1989/90	$2,500,000	-

*Post-sequestration level

Statement by Mr. Frenzel in support of funding for the Allen J. Ellender Fellowship Program before the Subcommittee on Labor, HHS, Education, Committee on Appropriations.

I would like to share some thoughts about the important contributions of the Close Up Foundation and to urge the continued support of this committee for the Allen J. Ellender Fellowship Program.

Since 1972, when I witnessed the positive responses of the first group of students and teachers from Minnesota to participate in CLOSE UP, I have worked closely with the Foundation's staff to involve as many young people as possible in the program, not only from my state, but from across the country. Over the years I have not only spoken with thousands of CLOSE UP students, but whenever possible, I have met with groups of educators and business leaders to urge continuation and expansion of the program. I remain convinced of its value for all citizens and my enthusiasm has, if anything, increased.

As Members of Congress, I'm sure each of us could site examples of programs which were started with the best intentions but which failed to achieve their goals. In the case of the Allen J. Ellender Fellowship Program, administered by the Close Up Foundation, I think it is safe to say that this is a program which has greatly exceeded the highest expectations of the original architects. Not only have we assured that less fortunate students are included in the Washington seminars, but we have provided a catalyst for the development of a broad range of additional activities in civic education. We can point to CLOSE UP with pride and satisfaction as a program which has consistently given this country an outstanding return for the small investment we have made in it.

With our support of the Allen J. Ellender Fellowship Program, I believe that we can predict with confidence that our investment will continue to generate dividends of learning and understanding about this great country.

BERYL ANTHONY, JR.
4TH DISTRICT, ARKANSAS

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WAYS AND MEANS
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

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May 19, 1986

The Honorable William Natcher
Chairman
Subcommittee on Labor - HHS - Education
Committee on Appropriations
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I would like to express my strong support for the Allen J. Ellender Fellowship Program administered by the Close Up Foundation, which provides the opportunity for our nation's teachers and young people to learn directly how our system of government operates. The Allen J. Ellender Fellowship Program is a significant investment in the education of our youth and in the maintenance of a strong and participatory democratic system.

All of us recognize the importance of a citizenry that assumes the responsibility of making informed and intelligent choices on critical issues of public concern. The Allen J. Ellender Fellowship Program's impact encourages thousands of young citizens each year to become better informed and more active participants in our society.

The evidence is very clear that this appropriation has proven to be a very important and effective expenditure of federal monies. A small investment of federal support through the Ellender Fellowships is multiplied again and again through the contributions of the business and philanthropic sector, through local community support of student work projects, and through the contributions of volunteer time by teachers and civic leaders across the nation.

Last year the Allen J. Ellender Fellowship Program appropriation of $1.5 million helped to create more than $16 million in privately generated corporate, philanthropic and tuition support for civic education. Consider the impact this program has had in my home state of Arkansas:

This year, 340 high school students and teachers from across Arkansas were able to spend an intensive learning week here in Washington. State and community educators tell me this is a tremendous supplement to the classroom experience and that students return home with a more active concern for public issues.

In March, nearly 300 more students participated in a one-day program in Little Rock, gaining a solid understanding of state and local government and important issues at home.

In schools throughout the state, other students and teachers are using videotapes and books prepared by the Close Up Foundation to create broader understanding and discussion on current issues.

This activity is occurring all across the country. The return on the investment of the Allen J. Ellender fellowships is substantial, not only in generating dollars and numbers, but also in building in our young people a foundation of good citizenship and good government. This is an investment that will provide benefits for years to come in our communities, states, and our country.

Sincerely,

Beryl Anthony, Jr.

Beryl Anthony, Jr.
Member of Congress

BA/lm

DANTE B. FASCELL
19TH DISTRICT, FLORIDA

FOREIGN AFFAIRS COMMITTEE
CHAIRMAN

ARMS CONTROL, INTERNATIONAL
SECURITY AND SCIENCE SUBCOMMITTEE
CHAIRMAN

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL
MEMBER

Congreſs of the United States
House of Representatives
Washington, DC 20515

CHARLES R. O'REGAN
ADMINISTRATIVE ASSISTANT

COMMISSION ON SECURITY AND
COOPERATION IN EUROPE
MEMBER

NORTH ATLANTIC ASSEMBLY
CHAIRMAN
HOUSE DELEGATION

CANADA—UNITED STATES
INTERPARLIAMENTARY GROUP
MEMBER, U.S. DELEGATION

May 15, 1986

The Honorable William Natcher, Chairman
Subcommittee on Labor, Health and Human Services,
and Education
Committee on Appropriations
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I have been a supporter of the Allen J. Ellender Fellowship Program for a good many years now and want to express again my commitment to the work of the Close Up Foundation.

Florida students and teachers have been participating in the Close Up Program since 1972, the same year that the Allen J. Ellender Fellowship Program began. Florida schools have been able to take advantage of the fellowships to promote a strong and healthy level of participation in the national program and to provide a model for the development of active state and local programs.

I am proud to say that Florida has been in the forefront of designing and implementing local and state citizenship education activities. Although the Ellender fellowships do not directly support these activities, they are the seed elements, the catalyst from which these local activities develop.

A very special example of the way Floridians have created locally-based learning experiences was a recent program on the budget. Participants from Boca Raton, St. Petersburg, and Sarasota met in their respective communities to study the budget process including an exercise in which they tried to balance the budget by taking the roles of key people in the budgetary process. Another part of the day's agenda was a teleconference with Senator Lawton Chiles in Washington interacting via C-SPAN with participants at the three Florida sites. This was a highlight of the program and particularly meaningful because the participants in Florida were not only high school students and teachers, but also senior citizens. In fact, the entire day's events were intergenerational--making this a pioneer program for Close Up.

Another broadening aspect that has occurred in the Close Up Foundation, and one that directly affects Ellender fellowship recipients, is the the development of several new alternate curricula for participants in the Washington program. One of these focuses on the United States from a global

The Honorable William Natcher
May 15, 1986
Page 2

perspective. This emphasis on international relations is an exciting addition, especially from my perspective as Chairman of the Foreign Affairs Committee. It continues to demonstrate Close Up's responsiveness to current educational needs.

I could cite many more examples of learning activities created by the Ellender fellowships, and I know that our colleagues on both sides of the aisle have examples from their own states as well. Many of us have followed Close Up's progress throughout the years and continue to offer our support for their relevant work in citizenship education. As has been stated before in various ways by many different people--the Ellender fellowships represent an investment in our future, an investment in democracy.

Many thanks for your consideration.

Sincerely,

Dante B. Fascell
DANTE B. FASCELL
Member of Congress

DBF/MS

TESTIMONY

OF

STEPHEN A. JANGER,
PRESIDENT, CLOSE UP FOUNDATION

PRESENTED TO

HOUSE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION

THE HONORABLE WILLIAM NATCHER, CHAIRMAN

MAY 12, 1986

Dear Mr. Chairman:

I am grateful for the opportunity to submit to you and members of the Subcommittee this statement respectfully requesting continued support during FY87 for the Allen J. Ellender Fellowship Program, administered by the Close Up Foundation. I know I speak for thousands of young Americans and their educators in expressing appreciation for your commitment to our work in years past. The positive impact of that support on individual family and community lives is almost too broad to be measured. The impact is there, however, and grows with each passing year.

Mr. Chairman, more than at any time in our nation's history, the strength of our democracy depends on the quality of the decisions that voters make, and those decisions depend on citizens understanding the democratic process and our country's fundamental principles.

Citizens continue to bear the primary responsibility for answering the complex questions of public policy, from health care to national defense. How can we prepare our children to be the kind of citizens who can tackle such questions?

We can prepare them through a cooperative, concerted citizenship education effort. No one group, not even our formal system of education, can do it alone, and there are obstacles to overcome.

The National Endowment for the Humanities recently released preliminary results from the National Assessment of Educational Progress, which show a number of problems ~~in~~ our schools in teaching the basics of American history and government.

The NEH study will not be completed until mid-1987, but the initial findings are disappointing. They include:

- among the high-school students surveyed, two-thirds could not place the Civil War in the correct half-century;
- one-third did not know that the Declaration of Independence was signed between 1750 and 1800;
- one-half did not recognize the names of Winston Churchill or Joseph Stalin.

Diane Ravitch, writing in The New York Times Magazine, quoted a college professor who said: "My students are not stupid, but they have an abysmal background in American, or any other kind of, history. They never heard of Daniel Webster, don't understand the Constitution, don't know the difference between the Republican and Democratic parties."

NEH succinctly described the danger implicit in such findings:

> Without an understanding of the history, principles, trials and successes of this country, our students can never be intelligent citizens; they can never contribute to the kind of effective self-government that democracies demand. Without knowledge of the world and of events before we are born, we remain as children, no matter what our age.

The problem is not limited to students; it carries on into the attitudes and practices of adult citizens. Many studies of college students and young adults have shown increasing detachment from public affairs and cynicism about public institutions.

In a work published by the Carnegie Endowment for the Advancement of Teaching, Ernest L. Boyer and Fred M. Hechinger summed up this trend:

> As a nation, we are becoming civically illiterate. Unless we find better ways to educate ourselves as citizens, we run the risk of drifting unwittingly into a new kind of Dark Age -- a time when small cadres of specialists will control knowledge and thus control the decision-making process.

Boyer and Hechinger point to the dropping voter turnout as a clear indicator of citizen apathy. In 1984, 54.5 percent of all eligible voters participated. They reflect on the kind of action needed:

> Obviously, no one institution in society can single-handedly deal with this massive challenge. Beyond the classroom, churches, libraries, youth groups, labor unions, senior citizens' organizations and many other groups should become greater sources of civic education. The media -- newspapers, journals, radio and television -- also have a powerful role to play.

The Close Up Foundation has been doing its part to meet this educational challenge since 1971. The Allen J. Ellender Fellowship Program, supported by every Congress since 1972, has bolstered CLOSE UP's activities and the results have been evident for teachers and students alike.

Participants in CLOSE UP's Washington-based student and teacher programs are the direct beneficiaries of the Ellender fellowships, and over the years, the participation rate has reached nearly 23,000 annually with a cumulative total of more than 180,000. During the current fiscal year, the Close Up Foudnation has generated private funding (corporate, philanthropic and tuition revenues) at a ratio of more than twelve to one over the Ellender funding. We're proud of this multiplier effect and work hard to achieve it.

Working from a solid base of support from Ellender funds, the Close Up Foundation has also been able to develop additional programs, not directly using Ellender dollars, but again created by virtue of the multiplier effect of the Allen J. Ellender Fellowship Program.

- PROGRAM FOR OLDER AMERICANS: This week long program brings people aged fifty and older to Washington on an intensive study visit.

- LOCAL, STATE AND REGIONAL PROGRAMS: Modeled after the national program, many communities across the country have designed their own citizenship education programs.

- TELECOMMUNICATIONS: The Close Up Foundation produces a regular series of telecasts over C-SPAN dealing with current issues and periodically sponsors teleconferences between Washington, D.C., and various locations around the country.

- PUBLICATIONS: Several academic publications are produced for use in the Washington-based program and in classrooms throughout the nation.

- SPECIAL STUDENT PROGRAMS: The Washington program has been adapted to serve special populations including hearing-impaired, visually impaired, physically handicapped, Spanish-speaking, international students and adjudicated youth.
  NOTE: Some of these special population students are direct recipients of Ellender fellowships.

Participant feedback is one of the best ways to evaluate the work of the Close Up Foundation. Recently a teacher from Oklahoma who has been involved in CLOSE UP for several years wrote to us saying:

> Don and I plan to continue to back CLOSE UP because we feel it is a very important program. The first student I gave the scholarship to is an excellent example of the impact the program can have.
>
> Palmara Campos was a bashful average junior student at Edmond High School when she was chosen to receive the scholarship. She was so enthusiastic about your CLOSE UP Program that she ran for an office of the senior class and won. She went to college majoring in Political Science and has had to work to support herself, but has passed the LSAT test and hopes to attend Law School.

Since CLOSE UP's inception we have heard this kind of story and thousands like it - stories that indicate that the CLOSE UP experience is a pivotal point in many students' civic lives. To exemplify this from another perspective, we would like to quote an essay from a recent 12th grade participant who attends a Department of Defense school in Panama.

> CLOSE UP is the program which gives high-school students from all over the United States and Department of Defense Dependents Schools a week in Washington, D.C., and a chance of a lifetime to see the government, the very structure of a democracy, our democracy, firsthand. It gave us an opportunity to get a close up view of our government, how it works, and who makes it work.
>
> Activities included seminars concerning key issues affecting our country today, both at home and abroad, and the basics of how our government works from the people to the President. We also had the chance to meet lobbyists and see who and why they influence our government and issues. Other activities included tours around the city, visits to many of the beautiful sights, and even the chance to meet one's own congressman.
>
> One of the most important of all these activities was the day on Capitol Hill. The day on Capitol Hill puts one directly

> where the process of our laws and liberties are made. On that day we were allowed to visit any of the congressional committees open to the public. Witnessing a committee hearing dealing with American aid to Ireland, we had the opportunity to see Speaker of the House Tip O'Neill. Following that, we attended a committee hearing dealing with aid for the "contras" in Nicaragua where we were able to see Defense Secretary Casper Weinberger testify. These were people we were used to seeing only on T.V., but here they were doing a job just like any other worker anywhere in the United States. Of course, what they were doing was on a greater scale; it made us realize that we the people of the United States are the ones who hold the true power in this country. These men in Congress, the Senators and Representatives, were there for us, our tools to a better government and country.
>
> One cannot begin to describe every detail of our visit. Seeing the Supreme Court in session, the laws being made, the policies, and just the democracy in action gave me true knowledge about our country which I could never have gotten from a textbook. During our visit the power and meaning of being an American could be seen, heard, and felt. Washington, D.C., became more than just the place the President lives, it became a place of hope, where the future of our country could be shaped. As we left the city we felt we had not only become better Americans, we were ready to touch others with the beauty of Washington, D.C., the beauty of democracy.

What this young woman says speaks eloquently for the effect that a CLOSE UP experience can have. For our young people to be able to take the reins as leaders and participants in our democracy, they must understand and value our system of government.

Despite the looming deficit we cannot shortchange our young people by leaving them ill-prepared to deal with our country's future. We respectfully request that the Close Up Foundation's appropriation remain at $1.7 million, the same as it was in FY86. We believe that this investment in our nation's teachers and students will continue to reap immeasurable dividends in education and in the quality of our civic life.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Labor, Health and Human Services and Education
Committee on Appropriations
United States House of Representatives

RE: Fiscal 1987 Health Appropriations

May 8, 1986

Background

The Administration's FY87 budget request for the Public Health Service is approximately $9 billion. This amount represents a decrease of over $1 billion from the FY86 appropriation.

The AMA recognizes the significant problems caused by huge federal budget deficits. However, the Administration has again targeted health programs for a disproportionate share of budget cuts. Moreover, the President is proposing major increases in the defense budget and has not proposed any cuts in certain areas such as Social Security. We believe that all segments of the federal budget must contribute to the savings required so that highly meritorious programs can receive adequate levels of funding. The Association makes the following specific recommendations.

National Institutes of Health

The Administration's FY87 budget request for the NIH is $4.9 billion. This amount is $417 million less than the FY86 appropriation. The budget proposes to support 18,000 research project grants, of which

12,860 will be continuations and only 5,140 will be new and competing awards. In FY86, Congress mandated 6,100 new and competing grants.

The AMA has a long history of support for the NIH. The NIH is a unique national resource of which all persons in this country can and should be proud. Its scientific stature and research contributions are unparalleled in the annals of human history.

The AMA strongly supports adequate funding for the NIH to enable it to keep pace with important research priorities. It is through the investment in fundamental research today that future scientific and medical breakthroughs that improve health and well being are possible, to say nothing of the future economic gains that many breakthroughs portend.

The Administration's budget proposal represents a short-sighted retreat from the federal government's strong commitment to biomedical research. The level of funding proposed would seriously impair the ability of NIH to attract new investigators and keep pace with important research priorities. It could also have a long-term adverse effect on the public health. Of particular concern is the proposed reduction in the number of new and competing research grants.

We urge Congress to appropriate sufficient funds for the NIH to enable the agency to continue to provide a stable environment for long-term research.

Centers for Disease Control

The Administration's budget request for the Centers for Disease Control (CDC) is $380 million, $27 million less than the FY86 appropriation. The request includes no funds for the vaccine stockpile when we are potentially facing the most serious shortage of vaccines we have seen in recent decades.

The AMA opposes the Administration's limited budget request for CDC. The budget request does not provide adequate funding for CDC's important public health programs which include the immunization program, the epidemic services program and the infectious diseases program. Congress should fund CDC's programs at a level that ensures that the agency can continue to fulfill its vital public health mission.

Alcohol, Drug Abuse and Mental Health Administration

The FY87 budget request for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) is $928 million. This amount constitutes a $72 million decrease from the FY 86 appropriation.

The AMA believes that the level of funding proposed by the Administration for ADAMHA is inadequate. Such a level of funding would hinder the agency from conducting important research into the prevention, treatment and underlying causes of alcoholism, drug abuse and mental illness. We are particularly concerned over the large cuts proposed in the National Institute of Mental Health given the epidemics of disability we currently face. These cuts would have a severe adverse effect on its programs. We urge Congress to provide adequate funding for ADAMHA.

Food and Drug Administration

The Administration is requesting $450 million for the Food and Drug Administration (FDA) in FY87, an increase of $28 million over the FY86 appropriation. However, the request includes $26 million in user fee collections from manufacturers. The FDA does not currently collect user fees.

The AMA believes strongly that adequate funding is essential for the FDA in order that drugs and medical devices are approved in a timely manner. Since 1981, the FDA has had a steady reduction in budget and personnel. The key issue raised by the President's budget is whether user fees are appropriate and if so, whether FDA will be allowed to use them for its mission. Given existing budgetary constraints, the AMA is concerned that in the absence of such fees the FDA will have no option but to slow down the approval of new drugs. Any user fees which are required must be available solely for the FDA to strengthen its resources, including adequate personnel, to provide for timely completion of the new drug review process. It is critical to quality patient care that beneficial drugs be available at the earliest possible time.

Office of the Assistant Secretary for Health

The FY87 budget request for research and prevention activities related to Acquired Immunodeficiency Syndrome is $203 million (plus an additional $10 million contained in the FDA budget). The amount is $31 million less than the FY86 appropriation of $234 million at a time when the epidemic continues unabated with 20,000 cases reported. The budget also includes $3 million for the Office on Smoking and Health, the same amount as in FY86.

The AMA believes the President's budget request for AIDS research and prevention activities is inadequate. An increase in funding for AIDS research is necessary because of the significant public health risk posed by the disease. It would be short sighted in the extreme to curtail the efforts that have brought such significant progress in AIDS research in such a short time. Increased funding is also needed for the important activities of the Office on Smoking and Health in its efforts to curtail and eventually eliminate smoking.

Health Planning

The Administration's FY87 budget proposes no federal financial support for state and local health planning activities.

The AMA supports this proposal. The philosophy behind the health planning program--centralized federal regulatory control over capital expenditures by health facilities for expansion and development--has been discredited as a means of guiding the rational growth of an efficient health care delivery system while at the same time keeping health care cost increases under reasonable control. The program is a relic of a public policy era when it was assumed that federal government regulatory approaches could provide for the rational distribution of health care services and as a consequence appropriately control health care markets and costs. We urge Congress not to fund this program.

Family Planning

The AMA has supported the family planning program since its inception and consistently has supported adequate appropriations for the program. We believe there remains a critical role for family planning programs such as those which have been developed under Title X of the Public Health Service Act. We urge Congress to continue to adequately fund this important program.

Conclusion

The AMA believes strongly that the NIH, CDC and other PHS agencies provide vitally important public health services. We are very concerned over the impact on the public health of the Administration's proposed cuts in PHS programs. We urge Congress to provide adequate funding for these important health programs.

American
Psychological
Association

TESTIMONY OF

Leonard D. Goodstein, Ph.D.

Executive Officer

American Psychological Association

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

COMMITTEE ON APPROPRIATIONS

on the subject of

NATIONAL INSTITUTES OF HEALTH

OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT

Fiscal Year 1987 Appropriations

May 1, 1986

The Honorable William H. Natcher, Chairman
2358 Rayburn House Office Building

1200 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

Mr. Chairman and Members of the Subcommittee, I am Dr. Leonard D. Goodstein, Executive Officer of the American Psychological Association (APA), and I am pleased to submit this testimony on behalf of the 87,000 members of APA. In this testimony, I will specifically address FY 87 appropriations for the National Institutes of Health (NIH) and the Office of Educational Research and Improvement (OERI) of the Department of Education.

NIH Research Budget

APA strongly urges the Committee to increase the research budget at NIH to fund at least 6500 new and competing research grants in FY 87. We greatly appreciate the strong support of this Committee in the past for increasing badly needed research funds at NIH. The Administration's FY 87 budget request for NIH would fund only 5,104 new and competing research grants, a decrease of 969 grants from the level recommended by Congress for FY 86. This number represents an even greater cut of 1,115 from the number of new and competing research grants funded by NIH in FY 85. We encourage the Committee to direct NIH to fund at least 6500 new and competing research grants for FY 87.

Health and Behavior

I would like to commend this Committee for its past support of the funding of health and behavior research by NIH. We urge the Committee to continue its support for research into the important relationship between health and behavior. Two recent reports, the Surgeon General's report "Healthy People" and the Institute of Medicine's report "Health and Behavior", document that 7 of the 10 leading causes of death in this country are in large part behaviorally determined and can be significantly reduced through changes in behavior. Many health problems, including heart disease, cancer and high blood pressure have environmental causes. We believe that behavior can be directly or indirectly linked to many of the nation's most debilitating illnesses and causes the greatest number of injuries in this country. Yet, the National Institutes of Health, the nation's largest source of funding for health research, has estimated that it spends less than 3% of its total budget in the areas of behavioral and social science research. This minimal figure is especially disturbing in light of the overwhelming data on the behavioral causes of ill health. APA strongly supports substantial increases in spending on important behavioral research at NIH in FY 87.

Last year, this Committee included in its report accompanying the FY 86 Appropriations bill language in support of health and behavior research at NIH. NIH recently released a report which estimated that a total of $105.3 million was spent on health and behavior research in FY 85 throughout its Institutes. This figure is $32.2 million less than an estimate given by NIH last year. Given the primary importance of behavioral factors in health promotion and disease prevention, APA recommends increasing the percentage of NIH funds presently spent on health and behavior research by at least 10% in FY 87. We urge the Committee to continue its active support of health and behavior research at NIH.

NIH Research Training

APA recommends a substantial increase in the number of research trainees supported by NIH in FY 87. The Administration's FY 87 budget request for NIH research training is $198.2 million. This figure would support only 9,250 predoctoral and postdoctoral trainees in FY 87, a substantial cut from the 10,623 trainees who would have been funded by the FY 86 appropriated levels for research training. Research training is vitally important to maintaining the vitality of all scientific disciplines, and cuts in research training funds at NIH will lead to severe shortages in adequately-trained researchers over the next decade.

In a 1985 report on the personnel needs for biomedical and behavioral sciences, the Institute of Medicine (IOM) advocated increased federal support for behavioral science research training. More specifically, the report recommended increased federal support at the predoctoral level in behavioral research. APA asks the Committee to support increased funding for NIH research training in FY 87. We strongly urge the Committee to specifically direct NIH to implement the recommendations of the IOM to increase funding for predoctoral research training support in the behavioral sciences.

Biomedical Research Support Grant (BRSG) Program

APA is especially concerned about the Administration's proposed elimination of NIH's $60 million Biomedical Research Support Grant (BRSG) program. BRSG funds are designed to financially supplement institutions engaged in health-related research. BRSG funds are traditionally used to for young investigators and innovative multi-disciplinary research. The elimination of the BRSG program at this time would be especially devastating due to already existing fiscal constraints. The $60 million contained in the FY 86 NIH budget for the BRSG program will be distributed to a total of 576 institutions, and we estimate that $12.25 million, about one-fifth of the total, will assist behavioral and social science researchers. APA strongly urges Congress to restore funding for the BRSG program at NIH.

National Institute of Child Health and Human Development (NICHD)

NICHD supports vital research on the psychological, social, biological, and environmental factors that influence the course of human development. Research supported by NICHD has furthered our understanding of both normal and abnormal development and has enabled us to prevent and treat developmental delays and disorders more effectively. Current research emphases at NICHD include: teenage pregnancy and childbearing; childhood injury prevention; intellectual and emotional development; prevention and amelioration of mental retardation; contraceptive development and evaluation; and normal and high-risk pregnancy and birth. Of particular interest to APA is the NICHD Center for Research for Mothers and Children which includes the Mental Retardation and Developmental Disabilities Branch and the Human Learning and Behavior Branch. In this regard, we are concerned about the constant decline in relative support for mental retardation research at NICHD from 1972 to 1985. We fear that this trend will continue if sufficient funds are not appropriated for the Institute. To continue its important work, NICHD must be funded at a reasonable level FY 87.

APA urges the Committee to support an NICHD research budget of $376.7 million in FY 87, a 17% increase over the FY 86 appropriation. This budget would provide support for 630 competing research grants, which would represent a funding rate of approved grants equal to the overall NIH rate of 34%. This budget would also restore research training funds to the FY 85 level of 702 full-time training positions. We also urge Congress to encourage NICHD to continue to strengthen its commitment to behavioral and social science research in terms of grant numbers and size of awards. Behavioral and social science research areas play a critical role in all the diverse research cited above. In the area of mental retardation, for example, between 70 and 80% of all cases is linked to psychosocial factors (e.g., poverty) rather than to specific biomedical causes. Behavioral and social science research have much to offer toward the understanding, prevention and amelioration of mental retardation and other developmental problems and disabling conditions.

National Institute on Aging (NIA)

The National Insititue on Aging (NIA) is the major source of federal funding for biomedical and behavioral research in aging. NIA's mission is to increase the knowledge of the aging process and associated physical, psychological, and social factors related to advanced age. At a time when the aging population in this country is increasing and when NIA is making progress in many areas of aging research, the Administration has submitted a budget request for FY 87 of $145.8 million, a reduction in the NIA budget of $11 million from the FY 86 level appropriated by Congress. Under this proposal, competing extramural grants would be decreased from 201 to 145, research training awards decreased from 240 to 195, and support for the 12 research centers (ten of which are Alzheimer's Disease Research Centers) decreased by $600,000. APA strongly recommends that NIA's FY 87 research budget be funded at least at the FY 86 appropriated level of $157.7 million.

National Institute of Environmental Health Sciences (NIEHS)

The National Institute of Environmental Health Sciences (NIEHS) supports research on the effects of exposure to toxic substances. Many of the most severe effects of toxic exposure include damage to the central nervous system which may lead to tragic psychological changes, including sensory, cognitive and emotional changes -- exposed individuals may become blind, mentally retarded or psychotic. APA urges the Committee to direct NIEHS to increase funding in the area of behavioral research.

National Heart, Lung, and Blood Institute (NHLBI)

As mentioned earlier, the important link between behavior and the prevention of such diseases as heart disease, high blood pressure and lung cancer has been documented in two nationally recognized reports by the Surgeon General and the Institute of Medicine. The Administration's proposed research budget for FY 87 at NHLBI is $785.7 million, a substantial $62.3 million cut from the FY 86 appropriated level. This marked reduction in NHLBI research funds would threaten behavioral research in such important areas as how behavior contributes to the development of oftentimes fatal diseases. APA strongly recommends increasing the research budget at NHLBI to at least the FY 86 appropriated level of $848 million.

National Cancer Institute (NCI)

Cancer presents another illustrative example of a disease which can be affected substantially by behavioral factors -- an individual's occupation, diet, and whether or not he or she smokes can increase the risk for developing cancer. Behavioral scientists have a major role to play in the prevention of cancer through research into these important behavioral influences. APA requests the Committee to encourage NCI to greatly increase its support of behavioral research, particularly in the area of cancer prevention. We support a research budget for NCI of at least the FY 86 appropriated level of $1.226 billion.

Department of Education - Office of Educational Research and Improvement (OERI)

APA strongly supports the Administration's proposed increase of $10.7 million in FY 87 for programs and activities under the Office of Educational Research and Improvement (OERI) in the Department of Education. The research and statistics presently available are significantly inadequate to provide educators with information on factors affecting the quality of teaching and learning in American schools. APA strongly recommends that a specified portion of this much-needed increase be targeted for individual investigator-initiated educational research activities. Field-initiated research has received minimal funding in the recent past because of the disproportionate emphasis of the Department on funding institution-based activities. Many of these individual researchers are engaged in innovative and critical educational research. APA urges Congress to support the Administration's FY 87 proposed funding level for OERI of $70.2 million, and to direct that a percentage of the proposed increase be earmarked for field-initiated research activities.

Thank you for the opportunity to present the views of the American Psychological Association on these important appropriations issues.

Statement on the need to support research on alcohol problems submitted for inclusion in the record of public witness hearings of the Subcommittee on Labor, Health and Human Services and Related Agencies of the Committee on Appropriations, United States House of Representatives by Robert Straus, Ph.D. May, 1986.

My name is Robert Straus. I am professor and chairman of the Department of Behavioral Science of the University of Kentucky College of Medicine in Lexington. I am also currently a member of the National Advisory Council on Alcohol Abuse and Alcoholism for the Department of Health and Human Services and chairman of a committee of the Institute of Medicine, National Academy of Sciences, that has been asked to review the current status of research on alcohol problems and to recommend directions and opportunities for future research. I have been involved in research on alcohol problems for forty years and served as chairman of the Cooperative (United States and Canada) Commission on the Study of Alcoholism in the early 1960's and as chairman of the National Advisory (to the Secretary of Health, Education and Welfare) Committee on Alcoholism from 1966 to 1969.

The magnitude of alcohol problems and the great human and economic burden that they impose on our society is well documented. I will simply note that these problems permeate every sector of our society including health and medical care, defense and national security, work and the nation's productivity, transportation, and the safety and well being of individuals, families and communities. The problems of alcohol are also varied. They encompass the short term or acute effects of alcohol on the human mind and body that we see in intoxication; the long term or chronic impact of sustained alcohol abuse that we see in various forms of alcoholism or alcohol dependency;

and the significant contribution of alcohol abuse to most major causes of death and disability including heart disease, several forms of cancer, diabetes, accidents, peptic ulcers, liver cirrhosis, and chronic brain and fetal alcohol syndromes. Afflicted individuals are not the only victims of alcohol problems. We are all potentially the innocent victims of those who are intoxicated or chronically incapacitated.

There are two major points that I would like to emphasize in this statement. The first has to do with the currently very hopeful and scientifically sound status of alcohol research. The second relates to the importance of maintaining momentum in this long-neglected but recently-stimulated field of research activity.

Federal support for alcohol research is quite recent and, relative to the magnitude of these problems, still very modest. Beginning in the 1970's, a Congressional mandate reversed an era of neglect and established opportunities for the support of research by the National Institute on Alcohol Abuse and Alcoholism. A new generation of investigators, unbiased by the stigma that once characterized the field, began to see in alcohol research opportunities for exploring some very basic scientific questions in genetics, biochemistry, pharmacology, physiology, the neurosciences, epidemiology and the social and behavioral sciences. Innovative scientific instrumentation opened new horizons for study and new techniques for data acquisition, processing and analysis added scientific rigor. Some of the traditional barriers to interdisciplinary research began to weaken creating a more favorable climate for the kinds of research required because of the versatile nature of alcohol and its capacity for permeating the human mind and body and because alcohol problems affect all sectors of our society.

Clearly, the late 1970's and the 1980's have seen a series of promising developments in both biological and behavioral research, a rapid expansion of fruitful opportunities for extending our knowledge, and an impressive increase in the number of scientists of stature who have become interested in investigating alcohol-related questions.

Ironically, despite modest recent increases in funds available for alcohol research, funding resources have not kept pace with the potential for important new knowledge represented by scientific activity and applications for research support. Each year, it has become increasingly difficult for qualified investigators to obtain funding for acceptable research proposals. At the same time, recent budgetary restrictions have made it necessary to limit payments on funded grants to levels below those that were recommended and approved. There is now a danger that outstanding investigators from numerous disciplines who have become interested in working on alcohol-related questions will become so discouraged by the odds against funding that they will turn their talent and attention to other topics and that many of the important questions on which they have been working will remain unresolved.

In addition to supporting research itself, it is important that the momentum of scientific involvement in research on alcohol problems be maintained by providing support for research training and for new investigators who represent our hope for the future.

The gap between opportunities and needs for alcohol research and research training and the resources available to support such research is continuing to widen, in part because of the recent success in attracting qualified investigators to work in this field and in part because of severe budgetary restrictions.

I deeply appreciate and respect the severe fiscal constraints that the Congress is now facing and the importance to future generations of establishing fiscal responsibility at this time. I would like to suggest that alcohol problems, like fiscal problems, will also plague future generations if we continue to neglect them. Because, with only a modest investment, we have recently made a hopeful beginning toward understanding these problems, I hope that the Congress will recognize the importance of protecting that investment by providing adequate funds to sustain this research activity.

It is estimated that the annual economic burden to society from alcohol problems is well over 100 billion dollars. In this perspective, the current revised fiscal year 1986 level of support for alcohol research and research training ($55.8 million) is modest, indeed. It provides only 50 cents of research funding for every thousand dollars of estimated economic cost. This level of funding is not adequate to support the research that is necessary if we are to acquire the additional knowledge needed to reduce this burden. Nor will it sustain the involvement of scientists of stature who have only recently been attracted to work in this field. In order to protect the gains and sustain the momentum so recently attained, I hope that the Committee and the Congress will support the research and research training activities of the National Institute on Alcohol Abuse and Alcoholism at least at the level of 75 million dollars for fiscal year 1987 and will provide an additional 14 million dollars in support of the Institute's essential informational and operational functions. This would still represent an investment of far less than a dollar for every thousand dollars of estimated cost plus untold human misery that alcohol problems impose on our society.

PUBLIC AND SCIENTIFIC AFFAIRS BOARD
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May 14, 1986

The Honorable William H. Natcher
Chairman, Subcommittee on Labor, Health
and Human Services, Education, and
Related Agencies
House Appropriations Committee
2358 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Natcher:

The American Society for Microbiology (ASM) wishes to submit the following comments on the President's proposed Fiscal Year (FY) 1987 budget for the National Institutes of Health (NIH). The ASM is the largest single biological life science society in the world with an active membership of over 34,000. Many of these individuals are engaged in biomedical research and are recipients of awards administered by the NIH.

The ASM considers federal support for fundamental research to be of the highest priority for the national well-being and security. We are encouraged by the generally positive approach to enhancing funding for such research to be found in the President's overall budget request for science in FY 1987. However, we are especially distressed to note that the NIH has been singled out for a significant decrease in its proposed budget. This decrease is counter to the recommendations of those officials within the Administration who have professional responsibility at the scientific level for administration of the NIH. In view of the critical role of the NIH in fundamental health-related research and at the cutting edge of biotechnology, we support the budget recommended by the Ad Hoc Group for Medical Research Funding as a minimum acceptable increase for NIH. This proposed budget takes into account both the current fiscal restraints and the scientific significance of the research supported by the NIH. The proposal would bring the increase for the NIH into line with those requested by the President for science support in other agencies, excluding the large increase for the Department of Defense (DOD). The overall figure recommended by the Ad Hoc Group for FY 1987 is $6.079 billion, which represents the current services level of $5.993 billion and a very modest figure of $86 million, or 1.4%, for program growth.

Because it has been severely tempered by the stark realities of the current budgetary problems, the Ad Hoc Group's proposal does not advocate optimal funding for NIH. We, therefore, recommend that an additional $60 million over the Ad Hoc Group's bottomline figure of $6.079 billion could be efficiently deployed over a wide range of activities in the National Institute of Allergy and Infectious Diseases (NIAID), the National Institute of General Medical Sciences (NIGMS), and the National Institute of Dental Research (NIDR), all of which fund the major portion of research in microbiology. In addition to NIAID's taking the lead role in research on Acquired Immune Deficiency Syndrome (AIDS), NIAID and NIGMS fund much of the original research in molecular genetics and immunology that is on the cutting edge of modern biology. The basic, untargeted research in the biomedical sciences supported by NIGMS is fundamental and provides the underpinning for all the disease-oriented research done by the other institutes. The NIGMS has sponsored much of the important research on recombinant DNA that is leading to direct payoffs such as the manufacture of important biological substances, including human growth hormone, insulin and interferon, the development of new vaccines against diseases that cause illness and death for millions of people, and the early diagnosis of certain genetic disorders. The NIAID is supporting exciting research on the immune system to learn more about its role in the development of chronic diseases such as cancer, arthritis and asthma. The NIAID is the main source of funding for research on infectious, immunologic and allergic diseases which account for nearly one-third of all visits to physicians. The NIDR supports essential research on carries and periodontal disease which are bacterial in origin and account for the most common infections in the nation costing billions of dollars annually for treatment. Infectious diseases as a group remain one of the major health problems of this country, resulting in approximately 27 million patient-days of acute hosptial care each year at an estimated cost of nearly $6 billion. Despite the fact that so much of the cutting edge fundamental science in NIH is sponsored by NIAID and NIGMS, these institutes continue to have some of the lowest paylines at NIH, reflecting the number of excellent research applications which they receive. This situation creates a special hardship for investigators supported by these institutes and important research efforts could be seriously impaired without additional funding.

We believe that it is essential to maintain the current pace of NIH support for research. Significant cutbacks of such support, even for a one-year period, would have a long-lasting effect and should be avoided if at all possible. Deferring research projects for even short periods of time can result in damaging effects that will be felt much later. Not only is research momentum lost, but research teams are disbanded and new research trainees cannot be attracted and retained. The instablilty and unpredictability associated with a stop-and-go pattern of funding for biomedical research results in losses in terms of time, personnel and costly start-ups of laboratories and retraining programs. Biomedical research is a long-term investment which should not be sacrificed in economically difficult times because it ultimately contributes not only to lower losses from sickness and death but also to more goods, more jobs and higher productivity.

In addition to our general concerns over the President's recommendations for FY 1987, we are dismayed by the increasing tendency of the Congress to provide funds that are inadequate to support the number of research grants which are mandated. Although we are pleased that the Senate Budget Resolution recommends that 6,000 new and competing grants be awarded by NIH in FY 1987, we are distraught that not enough of an increase may have been provided for the actual dollars required to support this number of grants. Because of chronic underfunding for basic biomedical research, and the effects of the Gramm-Rudman-Hollings cuts, both new and competing and noncompeting NIH grants are currently being paid at 10-15% below study section recommended levels. With the amount provided in the Senate Budget Resolution, this situation could be exacerbated in FY 1987. These cuts are of particular concern because they come on top of an already rigorous pruning that occurs during the peer review process in the study sections with respect to the direct cost part of the grant. This approach is intolerable in that grants are awarded to conduct specific research that cannot be done if the funds provided are inadequate. While we recommend that no fewer than 6,100 new and competing grants be awarded in FY 1987, we urge as strongly as we can that sufficient funds be allocated to adequately fund the number of grants mandated. To do otherwise would result in the further "downward negotiation" of the size of grants next year, and a point of diminishing returns in terms of research effort could be reached.

We are concerned by the suggestion from the Office of Management and Budget (OMB) that all funds designated for research on AIDS, including money to support noncompeting research activities as well as support for intramural scientists, be placed under the control of the Office of the Assistant Secretary for Health (OASH), rather than directly within the budgets of the individual institutes at NIH. We do not believe that the argument that says placing such funds in the OASH would enhance flexibility, is valid; rather, we suspect that such manipulation will actually result in a much less efficient use of money to support research into this critical area. It also represents a bad precedent for transferring funds for a specific disease out of NIH's research budget base. Under the conditions proposed, it becomes virtually impossible for the specific institutes, in particular the NIAID, to administer and maintain ongoing, meaningful programs of research into the prevention and treatment of AIDS. We strongly urge that funds for AIDS research be placed directly into the budgets of the individual institutes.

Second to none among our concerns is that at a time when there is already a perceived shortage of people trained in the area of biotechnology and an even greater decrease in the number of students matriculating into graduate programs in biology that the Administration suggests a virtual cessation of support for new graduate student training. This is a question of grave importance and the small amount of money to be saved is hardly worth the severe mortgaging of our future that it represents. We currently see a decline in the number of Ph.Ds matriculating into the biomedical sciences at a time when, scientifically speaking, we are in the midst of an explosion of research opportunities in the biomedical sciences that are unparalleled in history. In order to take advantage of these opportunities, we must make sure that we continue to train adequate numbers of qualified young men and women for careers in biomedical research. Acquiring the skills necessary to conduct basic biomedical research requires a minimum of 6 years on the job training (approximately 4 years predoctoral and 2 years postdoctoral after the baccalaureate degree). The Institute of Medicine (IOM) Committee on Personnel Needs and Training for Biomedical and Behavioral Research's most recent data shows a decline in bioscience Ph.D. production. The Committee wrote in its 1985 Report that the number of predoctoral trainees in the basic biomedical sciences supported in 1984 was 11% below the Committee's recommended level and "is on a steep downward slope." The Committee went on to state that in the next 5 years, a large number of faculty members will reach retirement and consequently the need for young faculty to replace them will begin to increase. The Committee further stated that National Research Service Award (NRSA) research training funds have declined since 1974, both in real terms and as a percentage of research expenditures, to a level below that previously recommended by the Committee. The Committee concluded by stating that the research training programs should be restored to the recommended number of positions by 1987 (12,825), and then adjusted to meet the increase in demand expected to begin in the late 1980s. The proposed budget of the Ad Hoc Group would enable a continuation of the funding of graduate education and support for new students.

We are concerned about the funding levels for two additional areas supported by the NIH Division of Research Resources (DRR), namely, Biomedical Research Support Grants (BRSG) and the Animal Facilities Improvement program. The President has recommended zero funding for the BRSG program in FY 1987. The amount appropriated for this program in FY 1986 was $62.6 million, which is a small amount of money compared to the enormous benefits of BRSG grants to medical schools, universities and colleges. These grants provide schools with the flexibility to support bright young men and women just starting in a research career and they play an important role in supporting established researchers who experience delays in funding. The BRSG grants prevent the closing down of research labs for short periods of time, and, more importantly, the costly start up when funding becomes available. The ASM recommends restoration of funding for BRSG support at the FY 1986 level. We also recommend at least an additional $10 million be added for the Animal Facilities Improvement program and $1 million to support the training of more laboratory animal veterinarians to meet the increasing demand created by new animal welfare policies. We strongly believe that Congress should provide the funds necessary for renovation and replacement of substandard animal facilities. According to a National Research Council survey, about 38% of all nonprofit biomedical research organizations have reported a need for remodeling their animal facilities and 16% need to replace them.

Finally, we are concerned, as are most other people involved in federal research, with the problem of determining indirect cost. Our concern is sufficient so that we have actually supported the effort of the Administration to place a one year cap of 26% on administrative costs. However, we are strongly opposed to the proposed decrease to 20% in FY 1987. We consider the number to have been arbitrarily determined. Rather, we favor an approach in which the recommendations on indirect costs of the Administration's own White House Science Council are taken into consideration and which would hopefully lead to more uniformity and equity in the determination of indirect costs rates at different institutions.

In summary, we consider the President's budget recommendation for NIH to be inadequate and severely harmful to the research potential of the nation. We urge you to increase the investment in the nation's basic health-related research effort at NIH to a level of at least $6.079 billion in FY 1987 and to consider the additional monies recommended for the NIAID, NIGMS, and NIDR. As expensive as research may be it is a bargain compared with the cost of disease. The funds involved represent a very small portion of the total health bill of the country, only 1.2% of a $456.4 billion expenditure, but are probably the key area if we ever hope to be successful in stabilizing health care costs. Health research is absolutely essential to the national interest and must be spared fro short-term savings to deal with the current deficit crisis. The economy of the US benefits from the excellence of NIH supported basic research which is often the forerunner of applied technology. We must maintain our competitive edge in science to ensure a strong economy, and scientific research should be one of the nation's highest priorities.

We appreciate the opportunity to comment and stand ready to assist the Committee during the budget process for NIH.

Sincerely,

Moselio Schaechter

Moselio Schaechter, Ph.D.
President, American Society for Microbiology

H. O. Halvorson

Harlyn O. Halvorson, Ph.D.
Chairman, Public and Scientific Affairs Board

Kenneth I. Berns

Kenneth I. Berns, M.D., Ph.D.
Chairman, Committee on Medical Microbiology and Immunology

ASIM TODAY

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

FOR THE RECORD OF THE

COMMITTEE APPROPRIATIONS

SUBCOMMITTEE ON LABOR--HEALTH AND HUMAN SERVICES--EDUCATION

HEARING ON ADMINISTRATION'S FY 1987 PROPOSED BUDGET

APRIL 28, 1986

american society of internal medicine
1101 VERMONT AVENUE NW SUITE 500
WASHINGTON, DC 20005-3547 (202) 289-1700

STATEMENT
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
FOR THE RECORD OF THE
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR--HEALTH AND HUMAN SERVICES--EDUCATION
HEARING ON ADMINISTRATION'S FY 1987 PROPOSED BUDGET
APRIL 28, 1986

The American Society of Internal Medicine (ASIM), an organization representing more than 20,000 physicians who are specialists in internal medicine, takes this opportunity to offer its views on issues related to Medicare contracting. The Society is particularly concerned that current funding levels for claims processing fail to respond to increased demands being placed on carriers during fiscal year 1986 and on the projected growth in the claims workload. ASIM believes that budgetary cutbacks for claims processing have already caused substantial hardship to beneficiaries and physicians.

Since the enactment of the Medicare fee freeze on physician fees and establishment of the "participating/nonparticipating program" in July 1984, hundreds of internists throughout the country have called or written ASIM to report an increasing number of errors and delays in the processing of Medicare claims for themselves and their patients. Problems with carrier performance have already created severe cash flow problems, and increased paperwork burdens on the administrative staff of participating physicians. A number of ASIM members have been forced to take out short-term loans to cover their overhead expenses as a result of increasing delays in payment. The increasing number of errors and delays in the processing of Medicare claims could adversely effect Medicare patients in the future as physicians become discouraged from participating in the program and find it increasingly difficult to accept assignment on a case-by-case basis. In addition, Medicare patients who pay their physicians directly on an unassigned claim basis have already incurred substantial out-of-pocket expenses due to delays in claims processing. Ultimately, the deterioration in claims processing due to budgetary cutbacks is undermining the congressional intent to reduce beneficiaries' out-of-pocket expenses by undermining incentives for physicians to participate or accept assignment.

The extent of the Part B reimbursement problems has led the Society to launch the Carrier Accountability Monitoring Project (CAMP), a program to collect Medicare carrier performance data on a long-term basis. The data collected on carrier performance nationwide will be reported to the Health Care Financing Administration (HCFA) and Congress at least annually. ASIM believes that this project will help HCFA and its carriers identify where problems may exist from the standpoint of physicians and their patients. ASIM recently completed a scientific survey of its membership and plans to make the results available to Congress and HCFA in early June.

The CAMP project grew out of the increasing frustration of internists who collectively treat 43 percent of the Medicare population. Specifically, ASIM members have encountered the following types of problems since the implementation of the fee freeze:

> Carriers are providing incorrect information on Medicare policy and requirements, particularly in relation to the requirements of the fee freeze, including erroneous listing of the participating status of physicians.
>
> Carriers have delayed payment of claims by as much as several months from the date the claim was submitted.

Carriers' phone numbers are repeatedly busy, and they have failed to answer letters from doctors and their patients, making it impossible for physicians' offices to contact carrier representatives to resolve problems.

During the conversion process to the HCFA Common Procedure Coding System (HCPCS) carriers have assigned codes that result in lower payments for the same service then was the case prior to conversion.

Carriers are automatically denying reimbursement for services that exceed prepayment screens (designed to check unnecessary utilization) without medical review of the circumstances in the individual case.

ASIM believes that a number of the problems mentioned above have occurred as a result of the actions taken by the Office of Management and Budget (OMB), Department of Health and Human Services (DHHS), and HCFA to limit federal support for Medicare claims processing. In fiscal years 1985 and 1986, OMB, DHHS, and HCFA have allowed a reduction in funding for claims processing of 7.8 percent, despite an increase of 37 percent in the claims volume during this period. To cope with the budget shortfall, HCFA has instructed carriers to increase their "days work on hand" from eleven days to eighteen days. ASIM sent a letter to DHHS Secretary Bowen on April 22 in opposition to the HCFA directive, urging him to rescind this policy (see appendix I). The additional slow down in payment of claims will cause substantial hardships for beneficiaries and will create disincentives for physicians to accept assignment.

ASIM is also concerned about the inadequacy of the Administration's FY 1987 budgetary request for Medicare contractors. The Administration has requested in its FY 1987 budget a funding level of $957 million, which is less than what Congress considered reasonable for 1986. The Blue Cross/Blue Shield Association has indicated that carriers will need at least a 14 percent increase in funding in order to assure prompt turnaround time on claims and efficient administration of the Medicare program. ASIM supports this recommendation, and urges the Appropriations Committee to allocate a sufficient level of funding to assure that carriers are able to administer the Medicare program efficiently in the coming fiscal year.

G-PH-0446/mkj

american society of internal medicine

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REPRESENTING
Internists and
All Subspecialists
of Internal Medicine

April 22, 1986

Honorable Otis R. Bowen, MD
Secretary, Department of Health
and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Bowen:

The American Society of Internal Medicine (ASIM) strongly opposes a recent directive from the Health Care Financing Administration (HCFA) to its regional offices ordering a slow down in the processing of Medicare claims.

The current back log in claims processing has already caused severe cash flow problems and increased paperwork burdens on the administrative staff of physicians. A number of ASIM members have been forced to take out short-term loans to cover their expenses (e.g. payroll, mortgage, supplies) as a result of increasing delays in payment. In addition, a growing number of errors and delays in processing claims have caused many ASIM members to question whether continued participation in the Medicare program is desirable. Medicare patients who pay their physicians directly on an unassigned claim basis have already incurred substantial out-of-pocket expenses due to the current delays in claims processing.

HCFA has instructed carriers to increase their "days work on hand" from eleven days to eighteen days to cope with budget cutbacks. These figures do not accurately reflect the additional time physicians and beneficiaries wait for payment because the figures do not include the time claims spend in the mail both to and from the carrier, and those times that carriers are not in operation (e.g., holidays). According to Jack Emery, Senior Washington Representative of Blue Cross/Blue Shield Association, the directive from HCFA "will mean a doubling of the length of time it takes to get paid." He added that "the only way we can (cope with the funding cuts) is to lay off people." This additional slow down in the payment of claims will cause substantial hardships for beneficiaries and will undermine the congressional intent to reduce beneficiaries' out-of-pocket expenses by creating a disincentive for physicians to participate or accept assignment on a case-by-case basis.

Honorable Otis R. Bowen, MD
April 22, 1986
Page 2

ASIM believes that pursuing this course is detrimental to physicians and unfair in its treatment of the elderly. The Society urges you to rescind this directive immediately.

Sincerely,

T Reginald Harris, MD

T. Reginald Harris, MD
President

TRH/be
G-PH-0089
cc: U.S. Representative Fortney H. Stark
Senator David Durenberger
U.S. Representative William H. Natcher
Senator Lowell P. Weicker, Jr.

Statement by

Stephen G. Pauker, M.D.

Professor of Medicine
Chief, Division of Clinical Decision Making
Director, Program in Medical Informatics
New England Medical Center
Tufts University School of Medicine
Boston, Massachusetts

in support of
the Proposed Budget for
The National Library of Medicine

For the Record
The U.S. House of Representatives Subcommittee on Appropriations
for
Labor, Health and Human Services, Education and Related Agencies

Mr. Chairman and distinguished members. It is a great honor for me to appear before you today. I am chief of the unique Division of Clinical Decision Making in the Department of Medicine of the New England Medical Center and am Professor of Medicine at the Tufts University School of Medicine. I am a founding member of the Society for Medical Decision Making, a multi-disciplinary organization of over 600 professionals engaged in practice, teaching and research in medical decision sciences.

I wish to express my strong support for the good work of the National Library of Medicine in the field of Medical Informatics and to endorse the budget proposed by the ad hoc group for health research funding and by the director of the National Library of Medicine. Within that proposed budget, I shall address my remarks toward the program in medical informatics and toward training programs in medical informatics research.

It has been gratifying to see the strong leadership your committee as provided for research and training in this arena in past budget cycles. As we all know too well, medicine is facing new and more difficult challenges at an ever increasing pace. One of the greatest challenges has been the explosive increase in technology and information. Certainly, the expansion of medical knowledge offers the promise of improving patient care and increasing the quantity and quality of life. However, before that promise can become a reality, medicine must develop the scientific basis for controlling that information and transforming it into useful medical knowledge. The science of collecting, organizing and utilizing such knowledge has recently been called Medical Informatics.

Within the past several years, the American Association of Medical Colleges has issued two reports emphasizing the central role that medical information science will hold in the next century. In 1984, the GPEP report recommended that medical schools designate an academic unit for institutional leadership in the application of information sciences and computer technology to the general professional education of physicians. A recently released follow-up report recommended that medical informatics should be integrated into the medical curriculum, that an identifiable locus of activity be established in each academic medical center and that the National Library of Medicine should continue to be the federal standard-bearer with respect to funding training, career development and research in medical informatics. That report suggested that the establishment of centers for excellence in medical informatics would be the most effective means of approaching the country's manpower needs in this arena.

As the need to train physicians to use and control medical information has become more pressing, it is paradoxical that the number of programs training physicians in these skills has decreased over the past several years. As academic medical centers are asked to realize that medical informatics must be a central feature of any educational program responsive to today's technologies, no less to even conservative estimates of the size of the medical knowledge base in the professional lifetimes of today's physicians, the requirement for trained faculty will surely increase. The need in 1986 is to train future medical faculties and to retrain today's faculties in the management of medical information. Sadly, our medical colleagues in Western Europe have devoted significantly more resources to medical informatics than has the medical establishment in the United States. Departments of Medical Informatics are not uncommon in European academic medical centers but have yet to appear in force here, in part, because of the lack of individuals trained to teach and perform creditable research in this domain.

At the present time, virtually all training in medical informatics is funded by the National Library of Medicine. For the past six years I have been privileged to be the director of one of the five current programs. Our fellowship program is directed at young physicians planning careers in academic medicine. On average, our program graduates two such physicians each year. A recent meeting of NLM sponsored trainees in medical informatics allowed an exciting exchange of ideas and the opportunity to reinforce this career path. Unfortunately, the total number of NLM trainees is under thirty. On average, most training programs require over three years of didactic work and supervised research. Thus, the total national output of the programs is quite small with respect to even short-term needs. If each academic medical center tries to establish a separate unit and if each unit requires from three to five trained faculty members to be effective, then it will be a very long time before these five programs can produce sufficient faculty. The requested budget of $2.4 million (a doubling of current levels) would provide funding for an additional 30 trainees. I believe that level to be optimal given the current faculty level available for staffing those programs.

If we are to be effective in recruiting bright young physicians into this career path, we must provide an intellectually stimulating community and a stable environment for research. Once again, the lion's share of funding for research in medical informatics is provided by the NLM. Unfortunately, many excellent projects go unfunded and talented young investigators are lured to other domains that provide a higher likelihood of stable funding. Sadly, the lack of a large vigorous scientific community within either academic medical centers or NIH itself makes it more difficult for young investigators in medical informatics to establish themselves professionally. Because medical faculties have few medical informaticians, criteria for academic advancement rarely include an appreciation of the special problems of basic research in this field, where the time frame for individual projects can be very long and where there is often little opportunity to publish in the standard prestigious journals. Thus, there is a need to foster the establishment of a sense of community and a set of role models for potential faculty members to emulate.

Unfortunately, the immediate need for faculty in most academic medical centers will dilute the size of the community in even current foci of research below a critical mass; the isolated physician will be most unlikely to compete successfully for research grants. Thus, in the short run, despite the pressures to disseminate medical informatics into each academic medical center, it will be important to maintain critically niduses for research and training. It is for this reason that I strongly support the establishment of centers of excellence in medical informatics. The $3.2 million in the proposed budget would provide core funding for perhaps four centers. Along with the proposed increase of $1.5 million (to a total of $5.6 million) for extramural research grants in medical informatics, these funds should go a long way toward establishing medical informatics as a viable academic career choice.

Lest the committee assume that medical informatics offers promise only for the future of medicine and little applicable to the practice of medicine in 1986, allow me to summarize some of the clinical work performed by our Decision Making Consultation Service. Our current research activities are funded largely by the extramural program of the NLM.

The practice of medicine is fraught with uncertainty--uncertainty about diagnosis, about prognosis, and about the implications of various therapeutic alternatives. Although the literature of medicine is organized by the responses of groups of patients and often describes the prognosis of the average patient in a given clinical setting, as physicians we almost never treat the mythical average patient. The clinician deals with individuals and much of the physician's clinical skill and judgment centers on the proper adaptation of the past experience with well controlled groups of patients to the uncontrolled prospective experience of the individual. Our consultation service offers advice to physicians dealing with unusual and complex choices in individual patients. The techniques of clinical decision analysis provide the physician with a deeper understanding of the clinical problem and the impact of the inevitable uncertainties of practice.

For example, we were asked to consider the optimal treatment for a 95 year old lawyer who had a new spot on his lung detected at an annual examination. One medical center advised him that he was too old to be treated; a second center, one specializing in cancer treatment, advised him to have immediate surgery. He was finally seen in our hospital and our group was asked to render an opinion. Unfortunately there are few data about the treatment of lung cancer in the very elderly. Thus, we developed an decision analytic model to explore this question. Our analysis suggested that optimal therapy would be empiric radiotherapy -- an option not even considered before we analyzed the case. In fact, he received that innovative therapy and did well. Over the past decade we have performed some 400 such analyses on problems that cover the full spectrum of clinical medicine -- from pediatrics to geriatrics, from psychiatry to surgery. Our analyses usually provide both the referring physician and the patient with a deeper understanding of the clinical problem and sometimes with an unexpected therapeutic plan. We have considered the optimal diagnostic workup of patients suspected of having AIDS, have written about the lack of necessity for routine renal biopsy in patients with nephrotic syndrome and the lack of necessity of routine cerebral angiography in patients with polycystic kidney disease, and have allowed patients to increase their participation in decision involving their medical care -- in domains ranging from prenatal diagnosis to coronary bypass surgery. The central point about these examples is not the specific recommendations but that the fledgling science of medical informatics can even now improve patient care.

In summary, medical practice is just beginning to face what will perhaps be its greatest challenge -- an explosion of knowledge and information which is proceeding at a pace which even now outstrips the cognitive styles taught in our medical schools. The medical profession has recognized the necessity for making basic changes in the educational process but one critically constrained resource is the number of health professionals trained in medical informatics and the amount of research that can be mounted in that domain. The National Library of Medicine is recognized as the world leader in the domain and should be given sufficient resources to allow the field to grow in an orderly fashion. The current pace would seem too slow, but unbridled enthusiasm would also be inappropriate. In 1986, there are so few competent medical informaticians that excessively high funding levels will not provide appropriate marginal gains. On the other hand, I believe that the budget proposed by the Director of NLM and endorsed by the ad hoc committee has been well designed and will increase the pace of professional development while still maintaining order and efficiency. I endorse that proposal enthusiastically and solicit your continued support for these important goals.

Thank you again for the privilege of providing you with additional information about the present and future importance of medical information science in improving medical care and providing an environment in which clinicians can make better decisions about the use of medical resources and the design of therapeutic plans. Given the substantial present and even greater future investments our nation will be making in medical research and health care delivery, it would seem wise to invest adequate funds to improve the decision making process and to provide our physicians with a scientific basis for dealing with the inevitable uncertainties in medicine and for optimizing the use of medical knowledge. I hope this testimony will be useful to you as you consider the budget of the National Library of Medicine and its request for monies for extramural research, for training, and for the establishment of centers for excellence in medical informatics.

AAHA Policy Paper

Government Affairs

STATEMENT

by the

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

for the

SUBCOMMITTEE ON LABOR-HEALTH & HUMAN SERVICES-EDUCATION

of the

COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

April 30, 1986

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
1129 20th Street, NW, Suite 400, Washington, DC 20036 202 · 296 · 5960

The American Association of Homes for the Aging (AAHA) appreciates this opportunity to express support for maintaining adequate levels of funding in fiscal year 1987 appropriations for Older Americans Act programs and for the research, education, and training programs conducted and supported by the National Institute on Aging (NIA), and the National Institute on Mental Health, Center on Aging (NIMH).

AAHA is a national nonprofit organization representing approximately 2,800 nonprofit facilities which provide housing, health care, long term care, and community services daily to more than 500,000 elderly individuals throughout the United States.

Older Americans Act Programs

Since its enactment in 1965, the Older Americans Act has played an important role in helping to meet the social service needs of the elderly, as well as research and training demands related to the aging process. The success of Title III programs in providing congregate and home-delivered meals and other supportive services is undisputed. The Act's nursing home ombudsman program has been important in helping to protect and enhance the rights of nursing home residents. In addition, Title IV of the Act has made strides in aging research and in the training of professionals who serve the elderly.

AAHA urges the Subcommittee to maintain at least current year funding levels for Older American Act programs. Several factors are currently operating which make current support essential. First, the demographics of aging make it clear that there is an increasing elderly population in need of services provided by the Act. Each year, half a million Americans join the age 65 and over group, with the 75+ segment of the older population growing the fastest. These, of course, are the people most likely to require the kind of supportive services offered under the Act.

Second, much attention has been focused on the impact of the Medicare hospital DRG prospective payment system on the post-hospital long term care needs of the elderly. With a hospital reimbursement system that provides an incentive for earlier discharge of Medicare beneficiaries, needed access by the elderly to post-hospital Medicare skilled nursing home and home health care services has been highlighted appropriately by several Congressional committees. But as starkly illustrated by the extremely limited nature of Medicare post-hospital benefits, a large portion of the elderly discharged from hospitals are returning home more frail, technically ineligible for Medicare covered services but in need of supportive services which are provided by Title III programs such as meals, personal care services, and adult day care. At a time when the elderly's level of care needs are increasing, as well as the sheer number of older persons, reduction in funding for Older Americans Act programs are clearly unwarranted and would have an adverse effect on the elderly who are now able to benefit from these services.

Third, there is likely to be an increasing demand on Older Americans Act programs to address the supportive needs of the elderly residing at home as other federal programs such as the community services block grant, low-income weatherization, and revenue sharing are targeted for major reductions or elimination by the Administration.

The Administration has proposed that Title III be funded at $669 million. While characterized by the Administration as an increase in funding over fiscal year 1986, (fiscal year 1986 funding has suffered a Gramm-Rudman reduction), this amount really represents merely a return to the level of funding provided in fiscal year 1985. Obviously, $669 million for Title III in fiscal year 1987 does not account for inflation, albeit smaller than in previous years, or for the increasing numbers of elderly in need of services. Given current pressure to reduce the federal deficit, however, AAHA supports the $669 million funding level as the minimal amount necessary to support Title III programs in fiscal year 1987.

The Association also urges the Subcommittee to reject the Administration's request for cuts in funding for Title IV programs and to appropriate at least $25 million, for these activities in fiscal year 1987 -- the pre-Gramm-Rudman fiscal year 1986 funding level.

Aging Research and Training: National Institute on Aging (NIA) and National Institute on Mental Health, Center on Aging (NIMH)

The Association is also extremely concerned over the Administration's proposed fiscal year 1987 cuts in funding for the National Institute on Aging (NIA) and the National Institute on Mental Health, Center on Aging (NIMH) which are being aggravated by the fiscal year 1986 reductions imposed by the Gramm-Rudman-Hollings Deficit Reduction Act. The need for continued research and research-related training into the aging process and the concomitant study of disorders occurring among the elderly is one strongly supported by AAHA. The subsequent translation of this research into improved diagnostic, treatment and management techniques is embodied in the commitment of AAHA members to the provision of the highest quality of care to these individuals.

National Insitute on Aging (NIA)

The NIA, through a series of intramural and extramural research programs and initiatives, has undertaken gerontological studies and projects on a variety of medical and psycho-social levels. Representative areas of research include the effects of aging on the immune system, the brain and nervous system, intellectual functioning, and personality and behavioral changes, as well as changes in response to various drugs and medications with increased age. NIA has also conducted several years of research related to the prevention and treatment of Alzeheimer's Disease.

Since 1984, ten multidisciplinary Alzheimer's Disease Research Centers have been established through funding granted to NIA. AAHA commends the creation of these centers and the Institute's commitment to the advancement of research into the cause, prevention, and treatment of Alzheimer's Disease. The Association has also identified this as a priority issue and has developed a member network on Alzheimer's Disease to provide a central vehicle for the sharing of information and resources. Most recently, an AAHA member task force has been appointed to work with the Association on determining how it can best serve the needs of AAHA members caring for Alzheimer's patients.

There are currently 2.5 million Americans suffering from Alzheimer's Disease, a degenerative condition, often progressing over a period of seven to twelve years, which results in loss of memory and judgement, agitation, and confusion. As the disease advances there is an increasing need for constant supervision and surveillance. This places an extremely heavy burden on family caregivers who, as in the cases of spouses, are frequently elderly themselves. The availability of home support services is expanding; however, nursing home placement is almost always required as the Alzheimer's victim's need for health related services and direct care extends beyond the caregiver's capacities. Due to the high degree of involvement required by staff in direct care behaviors, institutional management of the disease is also labor intensive.

The presence of Alzheimer's Disease can only currently be determined with absolute certainty through performance of an autopsy. Although exhibiting symptoms related to Alzheimer's, individuals may, in fact, be suffering from conditions whose causes are treatable and possibly reversible. Continued research into the development of a comprehensive assessment and diagnostic tool to identify year Alzheimer's Disease is essential to providing appropriate responses to the needs of its victims and to the timely and effective treatment of other conditions which may be masked by the presence of Alzheimer's symptoms. The cost of treating and maintaining Alzheimer's patients is huge in terms of both dollars, amounting to more than an estimated $20 billion annually in nursing home care, and in the vast amounts of time and skill invested by the broad range of health care professionals who are involved.

AAHA urges not only the continued and full funding of the ten existing Alzheimer's Research Centers, but, also advocates the extension of this program as proposed in the Comprehensive Alzheimer's Assistance, Research, and Education Act of 1985 (H.R. 2280), introduced by the Representative Edward R. Roybal.

National Institute on Mental Health, Center on Aging (NIMH)

The NIMH, Center on Aging, focuses on research, training, and services related to the mental health needs of the elderly. It is the major source of support for training clinicians specializing in the care of geriatric populations. NIMH has also recently concentrated on research related to Alzheimer's Disease, as well as on the study of Senile Dementia and depression, psychopharmacology and the chronically mentally ill elderly. One extremely important aspect of the training and research conducted by NIMH is the development of treatment intervention techniques and service delivery models involving clinical psychologists, psychiatrists, psychiatric nurses, and social workers.

The Administration's proposed budget reduction of 7 percent for fiscal year 1987 coupled with the effects of inflation would mean no new initiatives for NIA and reduced funding levels for all existing programs. The budget proposal would reduce monies for research project grants by $9.6 million, bringing the number of supported research grants back to 1984 levels. (This does not take into account the effects imposed by Gramm-Rudman-Hollings or proposed rescissions). NIA would be forced not only to support fewer research grants, but, to lower award amounts. Although the reduced funding levels proposed for

NIMH, 21 percent from fiscal year 1986 to fiscal year 1987, are not specific to the Center on Aging, the most severe reductions which have been targeted for this Institute are directed toward the clinical training and demonstrations programs. These programs would be totally eliminated under the Administration's proposals.

AAHA strongly supports the continued funding of these programs and the subsequent dissemination of information as vital to ongoing advances in the care of the aging in both institutional and non-institutional settings.

The number of individuals over 65 years of age, currently numbering 28 million, is the fastest growing segment of the U.S. population. According to the Bureau of Census, by the year 2050, one in eight Americans will be at least 75 years old. Our ability to provide services necessary to ensuring the highest quality of life to this population can only be enhanced through the continued funding and implementation of research, training, and education programs.

Again, AAHA thanks the Subcommittee for this opportunity to express its views and urges the Subcommittee to appropriate sufficient funds for fiscal year 1987 at least to maintain the pre-Gramm-Rudman level of commitment to these important aging services and research programs.

Statement of the
COALITION FOR ARTHRITIS AND MUSCULOSKELETAL DISEASES
on the
FY 1987 Appropriation for the
National Institute of Arthritis, Musculoskeletal, and Skin Diseases
to the
House Labor/HHS/Education Subcommittee on Appropriations

Presented by

Domenic R. Ruscio

Mr. Chairman and members of the Subcommittee:

My name is Domenic Ruscio and I am the Executive Director of the Coalition for Arthritis and Musculoskeletal Diseases.

If I may, Mr. Chairman, I would like to begin by thanking you and your distinguished colleagues for affording us the opportunity to submit this testimony. More importantly, our Coalition wishes to extend its appreciation for all that you have done to advance research in this and other important areas.

As I am sure you are aware, Mr. Chairman, arthritis and diseases of the skeletal support structure are among the most common causes of pain, disability, and disfigurement. Apart from the toll they exact in human suffering, it has been documented that the economic impact of these disorders exceeds $65 billion annually, when measured in terms of the added costs of medical care and lost productivity.

Mr. Chairman, approximately 31 million Americans suffer from arthritis, a disease that encompasses more than 100 different disorders of the joints and connective tissues, including osteoarthritis, rheumatoid arthritis, systemic lupus erythematosus, gout, and ankylosing spondylitis, or what is commonly known as spinal arthritis. Additionally, more than 40 million people are affected by bone and joint disorders, fractures, and injuries of the tendons and ligaments.

Congress recognized the severity and magnitude of these diseases when it created a separate National Institute on Arthritis, Musculoskeletal and Skin Diseases. This new institute, with the help of this subcommittee, at long last will provide an opportunity for a highly focused research program. For although much has been learned about these diseases and disorders, medical science has yet to discover a cure.

Research Needs

Mr. Chairman, rheumatoid arthritis remains the major crippling disorder among the rheumatic diseases. The findings from research over the past few years seem to indicate that rheumatoid arthritis is caused not solely by a single microorganism or a deranged host factor, but rather by different agents generating immune responses that later lead to chronic inflammation in those with genetically determined abnormal immune regulation and biochemical abnormalities.

Many new basic research methodologies have been developed and are now available for finite experiments to test this and other hypotheses. These new technologies include monoclonal antibodies, recombinant DNA, and molecular biology. In addition, new experimental animal models have been developed, such as that induced by immunization with type II collagen.

Mr. Chairman, this search for agents involved in an infectious etiology for arthritis needs to be continued and should include viruses and other latent or slow-acting microorganisms. Because immunological factors play such a major role in causing joint inflammation in rheumatoid arthritis and kidney and blood vessel inflammation in lupus cases, methods need to be developed for selective and specific suppression of those immune responses that mediate such conditions, but do not obliterate the body's defense against infections. The structure, function, and release of the mediators of inflammation, and the processes by which inflammation causes damage to joints and other tissues, must be better understood at the molecular level.

Major advances have also been made in understanding of bone cell regulatory factors, and support for this work, along with initial studies in clinical application of these new developments, should go forward. The continuous remodeling of bone is a complex, multifactorial process. Several controlling proteins recently have been identified and isolated. These new leads should be pursued.

Recommended appropriations for FY 1987

Overall, Mr. Chairman, the level recommended by the President for this newly established Institute is not sufficient to sustain the momemtum of on-going research activities, let alone mount a strong, new attack on these devastating illnesses.

While we are mindful of the difficult budget situation Congress faces, we believe that a reordering of the priorities set forth in the President's budget is necessary. With this in mind we recommend a funding level of $151,650,000 for the National Institute of Arthritis, Musculoskeletal and Skin Diseases.

The recommended support level for investigator-initiated research grants (RO-1) would fund 223 new grants in FY 1987, and a total of 612 new and continuation grants. At this level, the estimated award rate for new grants would be 34 percent, with a priority score payline of 170.

Specialized Centers of Research

Mr. Chairman, research in the areas of osteoarthritis, rheumatoid arthritis, and osteoporosis have progressed to the point where a concentrated multidisciplinary research effort is necessary. And certainly one of the most successful mechanisms for carrying out such an effort is the "Specialized Centers of Research". These specialized centers provide a valuable complement to an Institute's portfolio of investigator-initiated research projects, while providing a means of stimulating wider research interest in selected high priority areas. Perhaps more importantly, these centers insure that adequate support is provided for clinically oriented basic science and its application to clinical problems.

Mr. Chairman, we respectfully urge the Committee to set aside funds in the amount of $7.6 million to support at least nine Specialized Centers of Research, including three centers in each of the major disease areas of osteoarthritis, rheumatoid arthritis, and osteoporosis. These diseases afflict the fastest growing segment of our population, namely, those individuals over 50 years of age and unless we take advantage of the research opportunities now before us, the frequency of occurrence and impact of musculoskeletal conditions will become greater in the future.

Recommended staff levels

It should be noted Mr. Chairman, that at current personnel levels the new Institute cannot function as an independent entity. Under the NIH organization plan, 35 positions in the Arthritis and Rheumatism Branch and Laboratory of Physicial Chemistry in the NIADDK intramural programs are slated for transfer to the new Institute, along with 14 extramural personnel. When the administrative separation from NIADDK takes place, an additional eight slots are scheduled to be assigned to NIAMS.

In order to be minimally effective, the new Institute would require another 36 positions. Under the President's FY 1987 budget, $1 million additional is provided--but with no accompanying positions--in the Research Management and Support activity. If positions are made available this additional amount will permit the placement of 15 to 20 staff. An additional $1.5 million would then be necessary to provide the minimum of 36 additional personnel.

To conclude, Mr. Chairman, fiscal year 1987 marks the first opportunity Congress will have to act on its commitment to focus greater research emphasis on arthritis and musculoskeletal diseases. We urge you to do all you can to provide the new Institute with a solid foundation for the future.

Thank you, Mr. Chairman.

Statement of

Reverend Nicholas DiMarzio
Executive Director
Migration and Refugee Services
United States Catholic Conference

on the subject of

Refugee and Entrant Assistance

Submitted to the

Subcommittee on Labor,
Health and Human Services, and Education
Committee on Appropriations
U.S. House of Representatives

May 7, 1986

STATEMENT FOR THE RECORD

Reverend Nicholas DiMarzio
Executive Director
Migration and Refugee Services
United States Catholic Conference

As this country's largest voluntary resettlement agency, the United States Catholic Conference (USCC) has helped more than two million newcomers to begin new and productive lives in this country. The American public, through the U.S. government, has not only recognized and appreciated our role in this effort, but indeed has assisted by funding the kinds of programs that help refugees reach self-sufficiency--the goal shared by resettlement workers, policy makers, the American people, and refugees alike.

USCC has long been concerned about the domestic expenditures involved in refugee resettlement. We have seen that expenditures and admissions' rates are directly related, with Congress lowering refugee admissions ceilings as an example of an effort to control resettlement costs. We believe that there need to be--and can be--reductions in domestic refugee resettlement costs. But the Administration and Congress must make certain these cuts are appropriately applied in the proper areas.

Out of anxiety to make necessary budget reductions, take care not to sacrifice that long-term goal of refugee self-sufficiency to the short-term goal of FY1987 dollar savings. USCC is concerned that to reduce funding for certain programs that encourage and enhance refugee self-sufficiency will cripple refugees in their search for self-sufficiency, and lead to greater government expenditures in the long run.

Voluntary Agency Program

In the FY1986 Continuing Resolution, both Houses of Congress affirmed support for the so-called Matching Grant Program, agreeing that the full level of funding should be made available for this program. Yet the Office of Refugee Resettlement (ORR) FY87 budget request calls for a substantial reduction in the level of federal matching grants--decreasing federal investment to the program from $4 million (the appropriated FY1986 level) to $1 million in FY1987.

The Matching Grant Program has provided the voluntary agencies with the tools necessary to provide refugees with four months of cash assistance and support services, without accessing public assistance programs. Refugees in the program have achieved a significantly higher rate of employment, thus less dependency on welfare, than have refugees not in the program. All the data available from this program suggest that it is an extremely successful effort to resettle refugees in an efficient manner, without reliance on public assistance. ORR's own budget justification states that voluntary agencies participating in the Matching Grant Program were able to "demonstrate positive results in obtaining early employment for refugees."

At a time when federal agencies should be encouraging more effective and cost efficient refugee resettlement initiatives, the Administration's policy with respect to the Matching Grant Program is to phase it out over a two-year period. It is our view that this program should not only be maintained, but expanded to allow for additional numbers of refugees to participate.

Social Services

The ORR FY1987 budget request calls for a 35% reduction in the amount of funding available to provide employment-related social services. In most areas of the country, these social services programs funded by ORR are instrumental in achieving rapid self-sufficiency for refugees.

We believe the social services funds should be maintained at least in relation to the size of the eligible population. Projected FY1987 refugee admissions represents a 4% reduction over the previous year, yet the proposed cut in social services is 35%. Obviously, the extent of reduction for social services is substantially out of line with the rate of arrivals.

To ensure effective and efficient uses of social services funds, we encourage ORR to monitor the implementation of such programs within the states. Improvements can and should be made in some areas of the country. Cutting back so drastically in social services will only serve to diminish the effectiveness of programs where they are now working well.

Another concern we have with respect to social services is that as these funds are reduced, states will be increasingly inclined to award contracts to public agencies, at the expense of viable private agency initiatives. The public-private tradition of the refugee program, which has proven successful over the years, could be jeopardized.

To ensure equity and maximization of private resources, we propose that at least 51% of social services funds be made available to the private sector, particularly the voluntary agencies and ethnic community organizations.

Cash and Medical Assistance

We have long maintained that newly arriving refugees, having only transitional needs but otherwise employable, need not have, over extended periods of time, special categorical waivers for welfare eligibility. However, ORR's proposal to limit federal reimbursement to the first 18 months after the refugees' arrival, without regard for categorical eligibility, serves to diminish federal responsibility for the neediest population.

We agree with the thrust of the ORR proposal to remove disincentives to employment inherent in the current systems. But, by not reimbursing states for welfare costs associated with categorically eligible refugees after 18 months, the federal government is inappropriately shifting responsibility to the states.

A further exploration of options, by which cash and medical programs can be better tailored to the unique needs of refugees, is needed. Adjustments should be made but new approaches to providing transitional services to refugees must emphasize and encourage early employment for employable refugees, while maintaining appropriate support mechanisms for those refugees who are not immediately employable, especially those who are categorically eligible for AFDC and Medicaid.

Conclusion

Refugee resettlement has been perhaps this country's most successful private/public joint venture. The U.S. Catholic Conference is proud to have contributed to this powerful American commitment to welcoming the world's wandering homeless. We look forward to seeing next year's refugees take their first uncertain steps towards self-sufficiency in a new land--steps not fettered by poorly considered budget cuts.

The American Dietetic Association
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1667 K Street, NW
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April 28, 1986

The Honorable William Natcher
Chairman, Subcommittee on Labor, Health
 and Human Services, Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Natcher:

We are writing on behalf of the Society for Nutrition Education (SNE), a professional organization of nutrition educators and the American Dietetic Association (ADA), a professional organization consisting of 50,000 members from varying fields within the professions of dietetics and nutrition. The overall goal of both organizations is to promote the nutritional well-being of the American public.

The promotion of health and prevention of disease represents an important means of improving the quality of life for Americans as well as a potential means for slowing the rate of increased health care costs. Today, when six of the ten leading causes of death are linked to diet, our associations have made major commitments to nutrition education programs intended to reduce the public's risk factors for chronic degenerative diseases.

One aspect of these programs has been a cooperative project between SNE, ADA, and the Office of Health Promotion and Disease Prevention to initiate nutrition programs at the worksite. Because the majority of adults spend a considerable proportion of their time at work, the worksite is an important place for health promotion/disease prevention activities. Potential benefits include increased productivity, better job performance, decreased absenteeism and improved self-esteem. This cooperative agreement will help employers to fulfill a very real need to enhance the nutritional health of employees and their families and thereby help to minimize health care costs resulting from poor dietary choices. Additionally, this particular project can serve as a demonstration that the private sector can emulate in promoting sound nutrition programs at the worksite.

In addition to developing materials to assist employers in starting or expanding worksite nutrition activities ADA and SNE are coordinating member efforts to: indentify program and training needs of employers and consultants; collect and disseminate information on recommended resources and materials for worksite nutrition programs; train nutritionists and dietitians as worksite nutrition consultants; develop referral network to connect interested employers with qualified providers throughout the country. These efforts are being managed by the project director; however, our members are contributing their time, expertise, enthusiasm, and personal resources to these activities.

We are concerned that due to inadequate funding the Office of Disease Prevention and Health Promotion terminated the cooperative agreement with SNE and ADA as well as agreements with six other cooperators. We urge adequate funding and reinstatement for these cooperative projects in fiscal year 1987. In addition, we urge funding for a comprehensive evaluation of the worksite wellness programs such as the SNE/ADA/ODPHP project.

Thank you for your attention to our views.

We would like to request that you make this letter a part of the March 19, 1986 hearing record before the Subcommittee on Labor, Health and Human Services, Education and Related Agencies - Committee on Appropriations.

Sincerely,

Audrey Maretzki

Audrey Maretzki
President
Society for Nutrition Education

Anita Owen

Anita Owen
President
The American Dietetic Association

Testimony

Submitted

To

The House Appropriation Sub-Committee

On

LABOR, HHS AND EDUCATION

By

Reverend Leon H. Sullivan

On

The FY 1987 Appropriation

For

Title IIIA of The Carl Perkins Vocational Education Act

April 30, 1986

Mr. Chairman,

My name is Leon Sullivan I come to you with this testimony to thank you and the members of your committee for your forthright and straight forward advocacy for the poor and disadvantaged youth who until July 1, 1986 would have had no Comprehensive National Policy and Nationwide Delivery System To Give Them a Chance to Break Out of the Vicious Cycle of poverty, illiteracy, welfarism and A Permanent Dependency Syndrome.

I come to you to say thank you for your vote to appropriate 7.5 million dollars to fund Title IIIA of the Carl D. Perkins Vocational Education Act for FY 1986, which will begin to reach the states on July 1st.

I come to speak on behalf of the millions of black, hispanic & white youth in urban & rural America, for Indian & Asian-American youth who are to be found in pockets of poverty in America.

I speak because their voices cannot always be heard in the Halls of The National Policy Makers. Someone must speak for them.

Finally, Mr. Chairman, I have worked for the past 22 years with government & state legislatures, county administrators & Board of County Supervisors, with Mayors and City Councils to track the evils of youth joblessness, lack of youth training opportunities, a diminishing federal responsibility for solving the problem of a National Youth Crisis and the failure of business, labor, government and the general public to make the youth, America's future, a top priority item on the national agenda.

I have come to the conclusion that our only hope lies in the decision making that takes place in your committee that deals with federal appropriations for education and your counterpart in the United States Senate.

That is why I am here stating in written testimony an appeal to you to come to the rescue of America's youth. In the spirit of our Judeao Christian Heritage I feel compelled to ask you to "Throw Out the Life Line." Our young people are drowning in a sea of joblessness, hopelessness, depair, youth related crime, drug abuse, suicides, incarceration and anti-social behavior.

I call on you to throw them a life preserver. They have already gone down once when we failed to adopt any of the National Youth Policies Recommended by the late President Kennedy, the late Hubert Humphrey, the late late Adam Clayton Powell, the late Carl Perkins and the current chairman of the House Education and Labor Committee, Gus Hawkins.

They have already gone down a second time when the failure of CETA and Band-Aid approaches of the Job Training Partnership Act left us with a 60% to 70% black youth unemployment 37% hispanic youth employment and 18% all youth

I tell you gentlemen of the committee we cannot, we must not let these left out, pushed out, dropped out young people stay outside the American Economic Recovery plan. We must not fail in our effort to create a national comprehensive policy to reach the unreached youth that are "below the line" That has been drawn by all of our past & current Youth Policy Legislation.

The structurally unemployed and the so called HARD TO EMPLOY, the so called permanent underclass - who cant read, cant write, cant count and are not motivated to learning and self improvement, must not be permitted to drown because no one in the United State Congress stirred the conscience and steeled the will of the federal government to assume federal responsibility and trigger a positive response from state & local government and the private sector -

Gentlemen to paraphrase a Biblical quotation "If I did not come to you and cry out, the rocks would cry out!"

So, as I said in the beginning I come to speak not only for myself, as a veteran of the failed war against poverty & illiteracy of the last 40 years.

No, I come to speak for my own organization, OPPORTUNITIES INDUSTRIALIZATION CENTERS and for other community based organizations with demonstrated effectiveness in the delivery of Job Training Opportunities to the poor & disadvantaged youth in urban & rural America.

I come to speak in support of other testimony from my brother & sister organizations, such as the National Urban League, Operation SER, 70,001 Ltd., Operation Mainstream, The Labor Union Sponsored H.R.D.I., The National Puerto-Rican Forum.

I come to call on you to take the lead and point the way. Your sub-committee which sets the priorities for allocation of funds for education is & must be the "point man" on the S.W.A.T. team to attack the enemy of society that would rob our Youth of their rightful heritage in our democracy which boasts of being the most powerful nation in the western world.

Your committee, Chairman Natcher, hand in hand with Senator Lowell Weicker's committee on the Senate side must shine a light of hope into the dark corners of the Black Ghettos, the Hispanic Barrios, the Appalachians hollows the Indian reservations & urban pockets of poverty stricken whites.

Your committee has begun by taking the 1st step to fund the new creation -- The new investment placed in the hands of governors, & State Vocational Education Directors -- The New " Pre-vocational motivational Attitudinal Training System -- The First Nationwide systematic cooperative coordinating mechanism that brings community based organizations into partnership with local education agencies.

Your committee, by voting the 7.5 million dollars to fund Title IIIA of the Carl Perkins Vocational Education Act took the first step in what I hope will be a long journey - The amount of money is small by the standard of todays, federal budgeting - but the money is not the main thing.

Mr. Chairman, my staff has taken that small opening in the door of opportunity and pushed hard while we were awaiting your vote in the Senate House Conference last year. I met with Secretary of Education Terrel Bell before his departure. He called in from six states the vocational education directors -- the local education agency heads & my OIC leaders from each state to develop a strategy and action plan to implement Title IIIA. They went back to their states & began working. The results of that work are still coming in - but the bottom line is that "I have seen the future and it works!"

Governors have written me letters from these states indicating their willingness to cooperate. State legislators have responded by drafting and introducing state legislation to implement Title IIIA --- some calling for matching funds.

Local boards of education have begun to cooperate. Agreements are being signed for the first time between - C.B.O.'s and L.E.A.'s

A new wave of enthusiasm and a new beginning of creative coalition building is taking place among the C.B.O.'s themselves so that they can more effectively coordinate with local education agencies in planning cooperatively and preparing proposals for joint sponsorship in local school districts.

A new light of hope is shining in the eyes of some of our teachers who were beginning to feel a sense of hopelessness about this particular group of young people who were not being reached by the traditional school programs.

Yes, Title IIIA brings new hope and it offers a new beginning to parents, students, teachers, anti-poverty activists, clergy, business leaders and labor leaders, all of whom have up to this year complained, criticized or condemned our vocational education system as too little too late and too exclusive as far as the poor, bottom of the barrel young people are concerned, --- especially minorities and most especially the black minority.

So I say to you again, Mr. Chairman and members of the committee - money is not the main thing. The state director of vocational education in the state of Ohio reports that very small amounts of money are welcomed by the local education agency who can take little and do much. The State Director of Vocational Education in Kentucky has said that they are looking forward to the new partnership with a community based organization like O.I.C. as the outreach arm to bring in highly motivated, "basically prepared for vocational training" youngsters who had not been reachable before.

The Los Angles Mayor who is a Democrat & the Governor who is a Republican in the State of California have both embraced the new pathfinding & pioneering across a new frontier that the Title IIIA funding makes possible.

The school superintendent of Detroit, the State Voc Ed Director of Michigan, bi-partisan State Legislators and the Governor of the State have joined hands & hearts with General Motors Corporation and the Michigan State Baptist Convention to set in motion a State plan with our Michigan State O.I.C. Council to implement Title IIIA.

I could cite chapter and verse of indicators of success that we have found in the states of Connecticut, Kansas, Pennsylvania, Rhode Island, Wisconsin & the state of Washington where OIC has a fairly long history of cooperation with the Vocational Education "Establishment".

You may recall Mr. Chairman, that when Senator Spector of Pennsylvania introduced S2289 as an OIC and Community Based Organization Pre-Vocational Training Bill in 1984, we had already received high marks from the National Institute of Education for our four years Demonstration Career Intern Project with the Philadelphia

Board of Education and the Pennsylvania State Superintendent of Schools.

We had already demonstrated that we would maintain the same standard of performance and Fiscal Accountability, as well as criteria for teacher qualifications that the Teacher's Union required in the state of New York.

We have been endorsed by the Labor Department that invested 5 million dollars in a plan to expand the Philadelphia demonstration Project into five states.

Our first ten years of experimentation produced hard data that led congressional staff members and elected officials to include us in the Legislation for Employment & Training year after year through C.B.O. AMENDMENTS. Thus it was with enthusiasm that Senator Stafford of Vermont, included our proposed S2289 Amendment in his bill which became Title IIIA.

It was with genuine conviction based upon the outstanding record of O.I.C. in the State of Connecticut, that Senator Weicker proposed a 15 Million dollar amount to fund Title IIIA.

In addition, Mr. Chairman, when I had the good fortune to meet and talk with you personally with Senator Spector and again privately with a member of my staff, I was able to share with you the late Carl Perkins support for OIC through the years and indicate to you that this was an all American program that was cost-effective and productive, a real asset to our American Education System.

Finally then, may I point to our concern that all of these good indications that success is possible if Title IIIA is funded in FY 1987 and again in 1988 and 1989 by your committee may be in vain. Our fear is born of the knowledge that the administration through its office of management and budget has called for elimination of even the 7.5 million dollars voted by your Senate House Conference for FY 1986 funding.

Our outrage and righteous indignation reached new heights when we learned that this same budget recommendation advocated a 51% cut in the total Vocational Education Budget. This was a totally unrealistic, unconscionable, Draconian cut.

Really Mr. Chairman, this level of mindless, thoughtless, double crossing of the President's own advocacy of training for the poor and disadvantaged through self-help motivational basic skills training is unforgivable.

Moreover the hypocrisy of an administration whose split personality would permit the rape and murder of an entire generation's only chance to break out of poverty, welfarism, such hypocrisy deserves a stern rebuke. Nothing less than a bold clear and concerned reaffirmation of your 1986 position is needed.

In fact in my opinion it would not be beyond the realm of fairness & justice to our jobless unskilled youth standing on the brink of hopelessness, to make a small increase beyond the 7.5 million compromise to 10 million for 1987. This would make the point perfectly clear.

The message would be "Keep Your Hands off of our young people". If you do not intend to help them, at least do not hurt them. Don't stand in the way of the United States Congress that intends to help them!

Yes, Mr. Chairman in my testimony I wish to appeal to you and the member of your committee to let America know that there is hope. There is a light at the end of the tunnel for America's young people and it is not a train coming the other way.

I appeal to you as I said in the beginning of my testimony to "Throw out the life line" and the life preserver to keep our youth from drowning in the days and years ahead.

I urge you to give new meaning to the concept "such sums as as are necessary" by your vote and your collective action. Action which states that the original request for 15 million dollar was much less than is necessary and certainly the minimum amount of 7.5 million dollars is the floor beneath which we cannot and must not let this program fall.

I have faith in your wisdom and judgement born of so many years of experience in the appropriation committee and as chairman of the sub committee on Labor - HHS and Education.

I know from personal experience of your fairness & your compassion. I therefore, close my testimony by praying that God will guide and bless you as you make your own decision in your own way.

I am sincerely grateful as well to all of the members of your committee for what they have already done to help American's youth.

I am sincerely,

Reverend Leon H. Sullivan

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Committees:
Health, Human Services
& Aging (Chairman)
Economic Development
& Small Business
Financial Institutions &
Insurance
Ways & Means

Counties:
Clark
Clinton (part)
Fayette
Greene

David L. Hobson
State Senator
10th District

FOR IMMEDIATE RELEASE
MARCH 28, 1986

HOBSON INTRODUCES LEGISLATION TO ESTABLISH PRE-VOCATIONAL TRAINING FOR DISADVANTAGED YOUTH

Columbus -- State Sen. Dave Hobson, R-Springfield, today introduced legislation that will create a program to help train youth in basic educational, motivational, and readiness skills to prepare them for the job market.

"Senate Bill 373 calls for the State Board of Education to establish a state program of vocational education support by community-based organizations", Hobson said. "This bill will facilitate the pre-vocational training program which was authorized by Congress, under the 1984 Carl Perkins Act".

According to Hobson, the bill will establish state matching funds for the money already allocated by the U.S.Department of Education to the State of Ohio under provisions of the Carl Perkins Vocational Education Act. In part, the money will be used for community-based organizations that provide vocational educational support services.

"This program is aimed at disadvantaged youth between the ages of 16 to 21 years who lack the basic educational and motivational skills needed for traditional vocational education and for a job search", Hobson added. "These are the youth that because of economic or academic disadvantages, require special services or assistance in order to succeed in a traditional vocational education program".

"This piece of legislation is vital to increasing employment opportunities for this group of Ohioans", Hobson said. "It also will

-MORE-assure that we train a qualified workforce to make our state more attractive to new industry".

This legislation was brought to the attention of Senator Hobson by Rev. Leon Sullivan, a nationally recognized expert in employment and training, and founding chairman of the Opportunities Industrialization Center of America. Rev. Sullivan was the driving force behind the establishment of this pre-vocational training program on the federal level.

"The state of Ohio is the first to introduce this piece of legislation and if passed, will become the pilot project for the entire country", Hobson continued. "I also wish to thank Sen. William Bowen, D-Cincinnati, for co-sponsoring the bill".

"S.B. 373 is aimed at helping Ohio's youth and the economic future of our state, and I am pleased about its bipartisan support", Hobson concluded. "We hope the Legislature will deem this important bill a priority for passage in both Houses".

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TESTIMONY
OF
ROGER E. MEYER, M.D.
ON BEHALF OF THE AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY
AND
THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE

BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH
AND HUMAN SERVICES AND EDUCATION
HOUSE COMMITTEE ON APPROPRIATIONS

MAY 1, 1986

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My name is Dr. Roger E. Meyer. I am Professor and Chairman of the Department of Psychiatry and Scientific Director of the Alcoholism Research Center at the University of Connecticut School of Medicine. I am speaking today on behalf of two organizations who share a concern about the future of research on alcoholism, drug abuse, and the multiple forms of mental disorder. The Committee on Problems of Drug Dependence is a distinguished multidisciplinary panel that has been established under the general sponsorship of ten professional societies. For more than 30 years the committee was previously part of the National Academy of Sciences/National Research Council. It continues to advise relevant governmental and international organizations on the abuse liability and scheduling of drugs, and to sponsor the major annual scientific meeting in the field of drug abuse. The committee, therefore, has generic responsibility for encouraging scientific communication through its annual meeting and the publication of its annual monograph; and for expediting the application of scientific findings to public policy in the field of drug abuse.

The American College of Neuropsychopharmacology is an organization of more than 430 members from all relevant disciplines concerned about biological functionin the central nervous system, and its relationship to the causes and treatment of mental and addictive disorders. The ACNP membership represents the most significant group of scientists involved in this kind of research in the United States. This December, in Washington, the ACNP will be celebrating its 25th anniversay as an organization. The site and the timing are rich with symbolic meaning. Washington was the place where ACNP first met, when new drugs appeared to offer the first real hope ever for the mentally ill. It was Congress (in this city) which specifically mandated that NIMH conduct research in psychopharmacology, and it has been Congress which has authorized the funding over these years which has supported the research that has described the mechanism of action of many of these compounds; their real benefits and unfortunate limitations. As you know, it was easier for Congress in those times to authorize and appropriate funds for biomedical research than in the present decade. Indeed, even as this committee has moved to support equivalence between ADAMHA and NIH, Gramm/Rudman/Hollings poses a significant threat to both biomedical research support agencies.

ADAMHA-supported research has provided important new windows on brain function that, for the first time, demonstrate the relationship between specific mental dysfunction and brain abnormalities.

°Pet Scan Technology

Utilizing positron emission tomography (the PET scan), researchers at Washington University School of Medicine have found that patients with panic disorder who were untreated demonstrated increased metabolic activity at the right para hippocampal gyrus. Previous research had demonstrated that these episodes could be regularly triggered by lactate infusion. Appropriate pharmacological treatment of the panic disorder effectively prevents panic attack and its biological dimensions during lactate infusion.

°Studies of Regional Central Blood Flow

Researchers at the National Institute of Mental Health Intramural Research Programs at St. Elizabeth's Hospital here in Washington utilized regional cerebral blood flow technology to evaluate brain physiology and mental function simultaneously in medication-free patients with chronic schizophrenia, patients treated with standard neuroleptic drugs, and normal controls. One of the persistent deficits in schizophrenia involves difficulties with abstracting ability. The investigators at NIMH, using a standard psychological test of abstraction, demonstrated that both medicated and unmedicated chronic schizophrenic patients showed a paucity in dorso lateral prefrontal cortical activity (compared with control subjects) -- under conditions when all subjects were performing the same test of abstracting ability. This new approach to simultaneous examination of brain function and cognitive ability may help to clarify aspects of schizophrenia, potential risk factors in family members of patients, as well as potential new approaches to some of the treatment resistant aspects of the disorder.

•Imaging Studies in Alcoholics

Researchers at the National Institute on Alcohol Abuse and Alcoholism have been using the PET scan to delineate pathological brain function associated with alcoholism. Intramural researchers at NIAAA hope to access the new magnetic resonance imaging technology to clarify aspects of brain function in alcoholics, as well as children at risk for development of alcoholism. As you may know, researchers at Downstate Medical Center in New York and at the University of Connecticut have demonstrated electrophysiological abnormalities in children of alcoholics which may constitute a potential marker for alcoholism. Longitudinal research with these children, and the application of other technologies of assessment such as MRI, will be critical in the coming year.

Researchers supported by the National Institute on Drug Abuse are also involved in efforts to define risk factors in populations of individuals who seem to be at great potential for subsequent problems with substance abuse. Epidemiological studies supported by NIDA suggest that certain behavioral problems already manifest in the first grade in school were highly predictive of drug abuse in an inner city population. Children who did not demonstrate these behavioral abnormalities in the classroom were unlikely to be drug abusers in late adolescence and young adult life. Research conducted by a child psychiatrist at the New York University Medical Center has suggested that a substantial proportion of children with conduct disorder have abnormalities of cognitive function that are suggestive of deficits in brain physiology. The new imaging technologies utilizing cerebral blood flow, positron emitting tomography, and magnetic resonance imaging, in the context of methodology drawn from epidemiology, population genetics and the behavioral and social sciences, should help to clarify the relationship between brain function and individual risk.

The aforementioned research represents only a very small capsule of ADAMHA-supported programs, their current excitement and extraordinary potential. The various reports have appeared in the 12 months since I last came before your committee. A recent series on schizophrenia in the New York Times has served to highlight the extreme personal, familial, and societal costs of this disorder; the limited resources that have been made available for community care and rehabilitation; and the tremendous promise of research. The ADAMHA portfolio is necessarily interdisciplinary, and includes research in the psychological and social sciences, epidemiology, and of course neurobiology. Treatment outcome studies have identified the critical synergestic effects of medications and other forms of therapy for certain disorders.

What emerges from all this is that as research delineates problems more precisely, clinical practice can become more effective and costs can diminish. In the not so distant past, many patients with panic disorder were subject to expensive cardiovascular workups because of the non-specific cardiac nature of their complaints. After their workup by the internist, the patients would generally be referred to a psychiatrist for non-specific long-term psychotherapy. It is now clear that patients with true panic disorder are best treated with medication, while behavioral and other psychotherapy should focus on simple phobias and other concomitants of the disorder. That medication alone is effective in the vast majority of patients has had tremendous implications on the health care costs of this disorder, as well as the social costs of lost productivity. Parenthetically, untreated panic disorder also serves as a risk factor for alcohol and other drug abuse for some individuals.

This review of some of the research news of the past year was meant to highlight the real progress that is being made with the funds that have been made available to ADAMHA research. It is not easy for a political body, which represents the body politic, to support programs of research which promise non-specific future benefit -- in the face of current urgent realities. The budget deficit _is_ real. It has grown more urgent during the past five-and-a-half years than at any time in our history. By radio, the people are told that the fault lies with the Congress. But even David Stockman himself has begun to set the record straight; that it is Congress that has shown the wisdom to differentiate appearance from reality. It is the Congress, through staff work and committee hearings, which has been better able to identify the needs of biomedical research at ADAMHA and NIH than the staff at OMB. It will again be up to Congress to identify those needs and to identify the funds that will pay for these programs.

The Ad Hoc Group for Medical Research Funding, an organization whose membership has historically been concerned about NIH funding, is this year urging an increase in ADAMHA funding which would enable mental and addictive disorders research to "catch up." The budget that they recommend would restore ADAMHA "purchasing power for research and research training to the constant dollar level of 1974." In essence this group, and a coalition of citizen's organizations concerned about the future of research support for ADAMHA, have identified an alternative budget for this agency which is based upon professional judgments of present programs and critical need. The proposed budget recognizes the essential interconnectedness of individual research grants, research centers, research training of new investigators, research career development awards, support for equipment and support for intramural programs at all three institutes. The professional judgment budget calls for research support of $272 million at NIMH; $72 million at NIAAA; and $90.5 million at NIDA (Total: $434.5 million). These budgets are based upon a realistic estimate of what will be required to continue research supported by ADAMHA. The numbers are somewhere between the President's proposal ($348 million) which is inadequate, and the 1984 recommendations of the Institute of Medicine which suggested $300 million for NIMH and $100 million each for NIAAA and NIDA.

The President's recommendations would slash the number of new and competing grants at NIAAA and NIMH by 25% and by 12% at NIDA. NIDA has already imposed huge cuts in new and continuing grants in order to meet Congressionally mandated numbers of new grants in FY '86. NIDA has also been forced to cut back its Clinical Research Centers grants; NIMH would be unable to fund any new or competing research centers -- and six of the highly productive Centers would be abruptly terminated because of the shortfall in the President's budget proposal for this agency. Over the years, students of research policy and the history of science have highlighted the importance of mission-based research centers to the advancement of knowledge. This has been no less true in university settings than in technology-based industries. Research centers have become a critical part of ADAMHA research (as at NIH) -- but they have sometimes been forgotten in the "numbers game" around new and competing investigator initiated grants. The President's budget would arbitrarily dismantle those centers whose turn happened to emerge in the review cycle. This is not science policy based upon a critical review of excellence; it is more akin to Russian roulette.

Finally, your staff members know from their own visits to research programs around the country that clinical research grants are usually more expensive than laboratory based research. This means that fewer clinical research grants can be funded with a given amount of money -- and those agencies which support more clinical research will be obliged to make large cuts in individual grants in order to meet mandated numbers of new and competing awards. On all grants, there has been a tendency to delete essential items of equipment in order to reduce costs. The net effect on all research has been an aging of instrumentation -- and a special crisis of funding of clinical research programs.

In December, in this city, ACNP will be celebrating its 25th anniversary and a coalition of citizens' groups (the National Alliance for the Mentally Ill, the National Association for Mental Health, the National Depressive and Manic Depressive Association, and others) will be sponsoring a companion meeting for members of Congress, spouses, Congressional staff and the media. Your committee members and staff have understood the importance of research on alcoholism, drug abuse and other mental disorders. I hope that you will be able to attend the meetings and share in the pride of what you have helped to build. Congressional support for biomedical and behavioral research has been firmly grounded in the mixture of idealism and optimism that has produced dramatic returns for this country. Gramm/Rudman/Hollings calls for deficit reduction; it does not call specifically for dismantling the biomedical research programs of this country. There are ways to reduce the deficit while strengthening our biomedical and behavioral research programs. Your own support in the past has given some hope to the scientific community; to the mentally disabled and their families. We are all deeply grateful for your efforts.

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STATEMENT

of the

NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS

Orville H. McElfresh, President

before the

APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH & HUMAN SERVICES AND EDUCATION

UNITED STATES HOUSE OF REPRESENTATIVES

Hon. William H. Natcher, Chairman

on

FY 1987 Appropriations for the National Institute on Alcohol Abuse and Alcoholism

May 1, 1986

The National Association of Alcoholism Treatment Programs (NAATP) appreciates this opportunity to address the Labor, Health & Human Services and Education Appropriations Subcommittee on FY 1987 appropriations for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NAATP is the only national health care organization devoted solely to issues in alcoholism treatment. NAATP represents more than 500 private-sector treatment programs throughout the country, both non-profit and for-profit, offering inpatient, residential and outpatient regimens in both hosptial-based and free-standing settings.

For more than a decade, NIAAA has been the focal point within the federal government for advancement of alcoholism treatment, prevention and research. Since its inception in 1971, the Institute has played a vital role for the alcoholism field, as well as for society as a whole. Many of the seminal inroads we have made in dealing with alcoholism have been the direct result of findings made possible through NIAAA-funded research.

Alcoholism is estimated by the Institute to be the third leading cause of death and disability in the United States, trailing only heart disease and cancer in its magnitude. For several years, now, the Institute has also estimated that 85% of citizens in need of treatment for their alcoholism never seek or receive that treatment. Untreated alcoholism--its ravaging effects devastating nearly every organ and system in the body--is, indeed, today's "American Tragedy." Perhaps the greatest tragedy is that through modern techniques, constantly being researched and refined through efforts supported by NIAAA, alcoholism is a disease which is eminently responsive to appropriate treatment. Yet the stigma which surrounds this disease prevents many in need of help from seeking that help, and many family members and friends from encouraging it.

For many years, alcoholism treatment has been offered mainly on an inpatient basis in a hospital setting. One of the reasons this particular modality has prevailed is that most private insurance coverage for alcoholism treatment has covered only hospital-based settings. Since the inception of the Alcohol, Drug Abuse and Mental Health Block Grant, there has been a dramatic shift in the majority funding for alcoholism treatment from public sources to private ones. Additionally, and to some degree in response to this phenomenon, the alcoholism treatment field has developed what it calls the "levels of care" concept. This concept, which attempts to match the severity of each individual patient's disability with an appropriate intensity of service or level of care, needs to be recognized, researched and refined. NIAAA is currently funding this kind of research and, indeed, NAATP believes that such research should remain a prime priority of the Institute.

LEVELS OF CARE IN ALCOHOLISM TREATMENT

Just as there are several types of cancer and heart disease, there are, as well, many types or degrees of alcoholism. The variables, in diagnosis, can relate to gender, age, drinking history, family impact and history, employment (history and type), previous treatment experience, overall physical condition, motivation to recover, etc. To deal with the different levels of alcoholism, the alcoholism treatment field has developed three basic modalities, or levels, of care: inpatient, residential and outpatient.

The inpatient level of care is usually best for the severely sick, long-drinking alcoholic, who generally presents for treatment with concomitant medical and psychiatric complications, and who needs absolute separation from the trappings of everyday life. The residential level of care is an intermediate one, less medically-intensive and, thus, appropriate for patients not experiencing psychiatric or advanced medical problems, but who still need the benefit of a therapeutic milieu. Outpatient programming is considered appropriate when the alcoholic is in the earliest stages of the disease, and whose dysfunction has not become entirely unmanageable.

HOW TREATMENT COST IMPACTS TREATMENT CHOICE

One of the greatest issues confronting the public today is the problem of ever-increasing health care costs. The era of health care cost containment is upon us; we in the alcoholism treatment field welcome it because we firmly believe that appropriate alcoholism treatment stands as its own cost containing measure. This is, in fact, undeniable in comparison to the never-ending costs of treating the myriad consequences of untreated alcoholism.

The March, 1983 report of the Office of Technology Assessment, The Effectiveness and Costs of Alcoholism Treatment (Health Technology Case Study #22), eloquently concluded that "...it costs more not to treat alcoholism than to treat it." However, this landmark report underscored the fact that the notable lack of methodologically sound treatment assessment research in alcoholism leaves many questions unanswered. The basic question, in the absence of reliable research data, still remains: What type of treatment is appropriate for which type of alcoholic?

The answer to this question must be more than merely a function of cost. With the aforementioned stigma accorded alcoholism and its victims, we must guard against implementation of a public policy which simply states that alcoholics deserve only the least intensive--thus the least expensive--level of care. Certainly, this was the philosophy which prevailed thirty to forty years ago, when alcoholics were deemed incurable, and relegated to asylums offering little more than custodial care.

The alcoholism treatment field, itself, has responded to the recognition of different types of alcoholism with the "levels of care" concept. The field has been continually refining its diagnostic techniques, in order to determine the most appropriate levels of care for alcoholic patients. While insurance coverage--albeit to varying degrees--is available largely to inpatient, hospital-based programs, it is scanty, indeed, for residential and outpatient treatment. This is, certainly, a contradiction in terms with regard to cost containment.

As a result, the Office of Technology Assessment called for the creation of a "patient placement system," to match alcoholic patients to the appropriate levels of care based on the severity of their disease upon diagnosis and admission. NAATP has whole-heartedly supported this idea since it was advanced by OTA, and last year NIAAA began to move forward on the OTA's suggestion. NAATP believes that the continuing importance of this research should be underscored by this Committee in FY 1987. We need to continue to generate high quality and appropriate grant and contract proposals on patient placement and to fund the best research proposals.

CONTINUED EMPHASIS NEEDED ON TREATMENT-RELATED RESEARCH

Many historic and welcome advances have been made in the alcoholism field as a direct result of NIAAA-funded research. There is little doubt that the lion's share of FY 1987 appropriations for NIAAA will go toward biomedical research, to help us all better understand the effects of alcohol on the body, the very etiology of alcoholism, the interaction of alcohol with other drugs, etc.

While NAATP is highly supportive of the need for biomedical research, we also believe that greater attention should be paid to treatment assessment research. While many NAATP member programs regularly review and assess their treatment and its outcome, it is important that a respected, non-vested entity, namely the NIAAA, become more involved in this vital area of research.

Such an effort, generated by NIAAA, could answer so many of the questions raised by the OTA report, by the Health Care Financing Administration, by private insurors and employers and even by the alcoholism treatment field itself.

The information we seek relates to average length-of-stay, appropriate treatment regimens, development of common definitions of recovery, success/failure rates--and why. Without the answers, how can we determine an appropriate public policy on alcoholism treatment?

CONCLUSIONS AND RECOMMENDATIONS

The National Association of Alcoholism Treatment Programs respectfully recommends the following to the Committee:

1. That NIAAA continue its important emphasis on patient placement research, with assistance to the field in creation of quality grant and contract proposals on such research.

2. That the Committee appropriate $72 million for NIAAA for FY 1987, which would permit:

--Award of approximately 116 new and competing research project grants at Council-approved levels, providing needed funding for priority areas, including biomedical as well as treatment-related research;

--Full funding and expansion of existing research centers and the award of 2 new centers focused on high-risk populations and immunology;

--Expansion of the Intramural Research Program, with limited increases in personnel, equipment and facility renovations to take advantage of the newly-establish clinical research program located on the NIH campus;

--Expansion of the Research Scientist Development Awards with special emphasis on clinical researchers.

3. That Committee report language specifically direct that, from appropriations for the direct operations and staffing of the Alcohol, Drug Abuse and Mental Health Administration, funds remain available for the continuation of treatment financing research directed at the creation of an appropriate Medicare DRG configuration for alcoholism/drug abuse treatment, in cooperation with the Health Care Financing Administration.

4. That the Committee appropriate $576 million for funding of the FY 1987 Alcohol, Drug Abuse and Mental Health Services Block Grant.

NAATP wishes to express its support for NIAAA's many contributions to the alcoholism treatment field, both present and potential. There is a need for greater emphasis on treatment assessment and related research at the Institute which, in the current climate, surely approaches the importance of the Institute's biomedical research.

This concludes the formal statement of the National Association of Alcoholism Treatment Programs. We appreciate the opportunity to express our views, and respectfully request that this testimony appear in the offical record of this hearing.

Thank you.

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STATEMENT OF THE NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS, INC.

TO THE
SUBCOMMITTEE ON LABOR, HHS, EDUCATION,
AND RELATED AGENCIES

May 1, 1986

Social Security administrative expenses are financed almost exclusively by Social Security taxes. During their working years Americans pay for not only their Social Security cash benefits but also for the cost of administering the program. The American public rightfully expects courteous, dignified, prompt, and accurate service from Social Security employees.

While our employees work hard to deliver the type of service the American public deserves, we still have areas where improvement is needed. Short-sighted cuts in SSA staffing levels will ultimately reduce public services and will prevent improvements where they are needed.

The proposed fiscal year 1987 staff cut of 3,000 SSA employees is unwarranted. SSA trust funds, which finance agency operations, are growing as is the beneficiary population which needs to be served. If these cuts are enacted, several problem areas are likely to arise:

1. The quality of SSA's correspondence with the public can be expected to decline. SSA's clerical employment was reduced by 1,942 (19%) from October 1982 to September 1984.[1] In a recent GAO survey, about 50% of clients who received mail contacted SSA to determine its meaning.[2] Since clerical staff prepare correspondence, a shortage of clericals may lead to a deterioration in the quality and readability of SSA's correspondence.

2. SSA's phone service can be expected to deteriorate. A recent GAO survey found that less than half of the people who call SSA got through on the first try, and 25 percent had to call three or more times.[2] A recent phone survey by the Senate Aging

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[1] GAO Report, "Social Security--Actions and Plans to Reduce Agency Staff," March 1986

[2] GAO Report, "Social Security--Quality of Services Generally Rated High by Clients Sampled," January 1986

Committee revealed the quality of SSA's phone answers was below par. Continued decreases in staff will necessarily result in busier phone lines and will inhibit improving the quality of answers given to those who get through.

3. Waiting times in SSA offices can be expected to increase. GAO found about one in three visitors waited more than 30 minutes to be served.[2] Waiting times in several areas of the country are much worse than this. Reducing staff will only exacerbate existing problems.

4. Earnings postings problems will continue. The working public has a right to expect SSA to properly credit their account for work performed. While the speed with which SSA posts the bulk of earnings has improved, little progress has been made in crediting problem cases, many of which date back to 1978.

5. Recent law and regulations require SSA to resume reviewing the disability rolls. This review has been seriously curtailed this fiscal year because of budget constraints. This short-sighted delay actually costs the trust funds money as individuals who are no longer disabled continue to receive benefits.

Administering a program that pays over $200 billion a year in benefits is a serious business. An increase in benefit payment error rates of only 1/2 of 1 percent translates into $1 billion in erroneous payments. Staff cuts that increase error rates or reduce services to America's elderly and disabled must not be made.

We appreciate very much the chance to testify for this Committee of the U.S. House of Representatives.

We support the concept of research centers of excellence as a strategy most likely to produce new insights into the unresolved problems in the area of kidney disease and nephrologic disorders. Centers of excellence will provide opportunities for scientists in multiple disciplines to work on a single theme using their own unique areas of expertise. We feel that the Oregon Health Sciences University is particularly well qualified to function as a scientific center of excellence in the area of toxic injury to the kidney. As background it should be noted that many preventable diseases of the kidney are caused by damage directly, or indirectly related to drugs, chemicals, and environmental toxins. The epidemiology, causes and most importantly preventative techniques to avoid these insults to the kidney have largely been ignored by the research community over the last 20 years. Since environmental toxins and drugs are rapidly proliferating in our complex world, further research is necessary if we are to avoid generations of patients who require either dialysis or transplant because of slowly progressive toxic damage.

The nephrotoxicity laboratory under the direction of myself and Dr. Bennett has been involved in the development of animal models of disease caused by drugs and environmental toxins; in particular, antibiotics, the new immunosuppressive drug - cyclosporine and the effects of petroleum products have been studied. A modern, well-equipped laboratory is available for this research. Complementing this type of study are the many Ph.D. scientists in the Departments of Surgery and Medicine. Dr. Leena Mela-Riker, a nationally recognized expert, for example using subcellular techniques is working on the mechanisms of toxic damage produced by antibiotics. Other basic scientists within the Department of Medicine, include Cynthia Morris, Ph.D., an epidemiologist, Richard Bukoski a physiologist, and Daniel Schwass, a Biochemist.

Molecular biology, which will undoubtedly play an expanding role in solving the cause and providing direction for treatment of disorders involving renal cellular injury will be augmented when the new Institute of Advanced Biomedical Research opens this Fall. Additional research laboratory space will be available at the replacement Portland VA hospital which is on the same campus. It is anticipated that scientists from a variety of disciplines will be working in these new facilities. The Department of Pathology, under the direction of Donald Houghton has a national reputation in the area of toxic damage to the kidney. Under the center concept, regular meetings and scientific interchange will enhance the development of both ideas and applications that should culminate in preventative strategies. In addition, the new information and computer capabilities of the Biomedical Information Center that has been appropriated for the Oregon Health Sciences University will provide an immediate link for scientists who with other collaborators and investigators at academic institutions throughout the State. The School of Pharmacy at Oregon State University is currently involved in fundamental research on the causes of kidney cell damage.

Finally, any research effort needs readily available a large patient population in which to test strategies of prevention and treatment. The reputation of the Oregon Health Sciences University as a transplant center of excellence is nationally recognized and this large patient population will be available to implement protocols designed to prevent the toxicity of the immunosuppressive drug cyclosporine. In addition, the new Chairman of the Department of Surgery, Dr. Donald Trunkey is an internationally recognized expert in the areas of trauma and it is anticipated that many of the patients with trauma and kidney failure will be referred to the Health Sciences Center. Thus, research insights developed from basic laboratories can then be directly applied in the clinical arena.

In conclusion, the availability of scientists from basic science and clinical disciplines working together in one institution linked to one large information exchange network will facilitate research into causes of toxic kidney damage. Preventative strategy can be developed, tested and easily transferred to the clinical practice arena. This intensive effort could lead to better patient care and alleviation of some portion of the large economic burden necessitated by end stage renal disease programs.

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STATEMENT

OF THE

NATIONAL RECREATION AND PARK ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

ON

SPECIAL RECREATION PROGRAMS

SECTION 316, REHABILITATION ACT OF 1973, AS AMENDED

The National Recreation and Park Association extends its appreciation to Labor, Health and Human Services, and Education Appropriations Subcommittee Chairman William H. Natcher for the opportunity to submit the Association's views on funding of Special Recreation Programs for persons with disabilities for FY 1987.

The National Recreation and Park Association is a national, non-profit organization engaged in a wide range of research, education, policy and program initiatives in the area of parks and recreation. We have a membership of over 18,000 individuals, organizations and agencies performing an array of civic, professional and technical functions to meet diverse recreation demands. For the most part, our members are associated with public recreation and park systems. We have an affiliate organization in each state and the District of Columbia.

We urge you to support the continuation of funds for projects which initiate recreational services for persons with disabilities. Authority for this program is contained in Section 316 of the Rehabilitation Act of 1973, as amended.

RECOMMENDATION: The National Recreation and Park Association recommends a FY 1987 appropriation of $4.5 million for Special Recreation Programs for persons with disabilities.

This request reflects a new priority towards enhanced community integration, an expanded scope of service delivery, and a more permanent and sustained contribution to comprehensive rehabilitation services.

In FY 1986, program priority has been given to supporting services in the least restrictive environment that enable increased independence and integration in the community. Recent research on the efficacy of Special Recreation Projects has shown that federal grant support can improve the rehabilitation and independence of persons with disabilities. In addition, Special Recreation Program funding has increased cooperative efforts amongst therapeutic recreation specialists in clinical and community settings thereby assisting persons with disabilities in transitional adjustments to work and community living. Projects provide a broad range of activities and related experiences including sports, music, dance, arts and crafts, camping and scouting, as well as leisure education and resource development.

Despite evidence of progress, the need for recreation as an integral part of community integration continues to exist. Recreation and leisure involvement is not an automatic part of a disabled person's life, easily incorporated into their activity. A nationwide survey of 1,000 disabled persons by Louis Harris and Associates revealed that these individuals socialize less with friends and family and are less involved in community activities than those without disabilities.

Continued need is also evident in the more than 200 proposals that come to RSA each year for funding special recreation projects under Section 316 of the Rehab Act. Only 28-30 proposals can ever be funded. Over the past five years, 133 funded programs have resulted in an expansion of recreational opportunities which have directly impacted the lives of more than 100,000 people with disabilities. However, a major constraint to the success of these programs in terms of Congressional objectives is the one year funding limitation. That is, the projects barely have time to get started before they lose funding, making it exceedingly difficult to find local sources to continue funding the project. Nevertheless, a number of model programs have been able to do this because of their demonstrated value and worth.

The National Recreation and Park Association will be pleased to provide additional information or other assistance to the Appropriations Subcommittee on Labor, Health and Human Services, and Education, if necessary.

Statement of the
NATIONAL RURAL HEALTH CARE ASSOCIATION
on the
FY 1987 Appropriation for the
Health Resources and Services Administration
to the
House Labor/HHS/Education Subcommittee on Appropriations

Presented by

Robert Van Hook, Executive Director

Mr. Chairman and members of the subcommittee-

My name is Robert Van Hook and I am Executive Director of the National Rural Health Care Association.

I would like to begin by thanking you for affording us an opportunity to submit testimony to this distinguished panel. I would also like to extend our gratitude for your understanding and generous support of the issues we are here to discuss today. And believe me, we can appreciate just how difficult your task will be in the coming months.

By way of background, the National Rural Health Care Association, or NRHCA, is a nonprofit organization whose members share a common interest in rural health care. The Association includes administrators, educators, government workers, physicians, and other health professionals who serve in hospitals, community and migrant health centers, private practice, and government and educational institutions.

In a word, Mr. Chairman, the goal of our Association is to improve health care for the 59 million Americans now living in rural communities throughout the country.

There are, of course, many reasons why one would want to live in a rural area. Unfortunately, health care is not one of them. Some of the factors that exacerbate poor health conditions in rural communities are:

- first, most rural communities contain a disproportionate number of the poor and the elderly--persons who generally require more medical care than the general population; the Census Bureau, by the way, reports that rural poor now outnumber their urban counterparts;

- second, individuals living in rural areas must travel longer distances in order to obtain health services; as a consequence, many choose to postpone or forgo treatment altogether, only to face more serious and often more expensive health problems in the future; I would also add that these individuals are less likely to have even the most basic health insurance coverage;

- third, persons residing in rural areas are more likely to be living in substandard housing and working in some of the most hazardous and economically stressed occupations, such as mining, forestry, or farming.

To give you some idea of how these factors actually affect people's lives, let me cite from a recent study conducted by the Public Voice for Food and Health. This consumer group examined vital statistics data from the eighty-five poorest rural counties in America, for a period extending from 1980 to 1983.

Its major findings were that infant mortality and low birth weight rates--important indicators of health status--were significantly higher in rural poor counties than in the rest of the nation. In 1983, for example, the infant mortality rate among the rural poor was 16.29 per 1,000 live births compared to 10.89 per 1,000 live births in the rest of the country.

Even more troubling is the fact that this significant gap between rural poor counties and the rest of the nation is growing worse. The difference in the infant mortality rate grew by 39 percent between 1981 and 1983, while the margin in low birth weight rates grew by 38 percent between 1980 and 1982.

Mr. Chairman, what I have just cited is but one facet of a very serious, I daresay, deplorable situation that exists in this country. Sad to say, the problem could worsen if action is not taken soon.

I realize that Medicare reimbursement does not fall within the jurisdiction of this subcommittee, but I want to take the opportunity to urge your continued interest in correcting the inequities built into the prospective payment system. As you know, the current system calls for an urban/rural reimbursement differential that results in rural hospitals receiving on the average 55 percent of what urban hospitals receive for delivering the same services. Under the circumstances, no matter how cost-effective, most rural hospitals are unable to compete within this inequitable reimbursement system.

Rural physicians, too, are disadvantaged as a result of lower payment rates for the same services as their urban counterparts.

Last year, the report accompanying the Labor-HHS appropriations bill called attention to this problem by directing the Health Care Financing Administration to take a closer look at the issue and come up with some recommendations to remedy it. Our Association applauds your actions and we look forward to seeing HCFA's recommendations.

But as you well know, the health care problems of rural America go beyond issues of reimbursement, which is why we are submitting this testimony.

Over the past several years, this subcommittee has played a vital role in addressing the special health needs of rural America. Much of this has been accomplished because of this subcommittee's long-standing support for community-based primary care programs--programs which have proven to be the tap root for delivering effective, high quality health care to medically underserved and disadvantaged populations. Time and again, studies have shown primary care programs have: improved access to health care; significantly reduced hospital admissions, lengths of stay, and inpatient care costs; and generally improved the health status of those who use the programs.

But, again, we must not allow past achievements to cloud the fact that serious challenges remain. It is essential, therefore, that support for the Community health centers program be sustained. We must also be mindful of the fact that the so-called physician glut has not trickled down to rural areas, so it is imperative that National Health Service Corps activities in this regard be strengthened, not diminished.

Mr. Chairman, rural areas face a myriad of problems, many of which are quite different from those confronting metropolitan and suburban communities. And, unfortunately, there is no single federal program targeted to address all of the needs of rural comunities. Support is provided instead through a variety of programs, many of which are funded through the Labor-HHS appropriations bill that this subcommittee oversees.

Mr. Chairman, our Association respectfully requests that the subcommittee approve the amounts listed below for programs that we believe are vital to the health and well-being of rural communities throughout the nation. Thank you for your time and consideration.

	Recommendation
Community health centers	$400,000,000
Migrant health centers	45,400,000
National Health Service Corps	75,000,000*
Maternal and child health	478,000,000
Black lung clinics	3,400,000
Family medicine/general dentistry residencies and training	37,000,000
Family medicine departments	7,000,000
Area Health education centers	18,000,000

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*Pending reauthorization

AMERICAN ACADEMY OF OPHTHALMOLOGY

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April 17, 1986

The Honorable William H. Natcher
Committee on Appropriations
Subcommittee on Labor, Health and Human
Services,
2358 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Natcher:

The American Academy of Ophthalmology would like to comment on proposed 1987 appropriations for the National Eye Institute. The Administration's budget request for $179,201,000 is both unrealistic and inappropriate: unrealistic, as last years' appropriation totaled $195,072,000 (prior to sequestration), reflecting a modest increase over the 1985 actual appropriation; inappropriate, because this amount would deal a devastating blow to many areas of eye research and would ultimately contribute to greater costs expended for medical care.

The Academy supports a modest increase (10%) over a current services level of $222,000,000 to $245,000,000 (based on the $195,000,000 1986 appropriation). Highlights of a $245,000,000 Planning Budget include:

- Program distribution which provides essentially the same increase over the current 1986 estimate for each extramural program activity.

- Research Project Grants:
  Award rate 57% vs. 36% in the President's budget request;
  Average costs restored to historical levels;
  If fully funded, the award rate would result in 395 competing grants.

- Core and Center Grants:
  Increases numbers supported from 27 to 38.
  Provides full committed amounts for noncompeting;
  Increases average costs of competing to $250,00;
  This level would result in new construction, the upgrading of equipment, and renovation for animal research.

- Other Research:
  More than doubles the number of Research Career Awards supported;
  Increases the number and amounts for small grants by 150%;

This is extremely important to carry on research and is targeted as an area to increase resources for training.

- Instrumentation/Construction:
  Provides $10 million;
  The President's request included no funds for this program.

- Research Training:
  Increases number of trainees from 190 at the President's Request level to 298;
  This level reflects a request for 11 training grants; NEI has only been able to fund 3 at the present level. NEI would like to fund a total of $8,000,000 in this area, allocating $3,000,000 to contracts and $5,000,000 to research.

- Research & Development Contracts:
  Increases amounts available by almost $3,000,000 to allow initiation of important new clinical studies.

- Intramural Research - Research Management and Support:
  Modest increases included for additional staff.

Each of these needs for the National Eye Institute is acute. The request of $245,000,000 for NEI is based on a 6% share of the total Citizens' Budget request for the National Institutes of Health. This is in line with previous allocations to the National Eye Institute.

Material included with this letter emphasizes significant recent accomplishments in many areas of eye research and outlines priority areas for future research. In addressing these critical areas, the continued success of the National Eye Institute is predicated on the annual levels allocated to it.

The American Academy of Ophthalmology appreciates your strong support for the National Eye Institute. We request that this be submitted as part of the Hearing record in lieu of oral testimony. Thank you.

Sincerely,

Hunter Stokes, M.D.
Secretary Designate
Governmental Relations Secretariat

Retinal and Choroidal Diseases

Significant Recent Accomplishments:

- In an NEI-supported clinical trial, the Early Treatment Diabetic Retinopathy Study (ETDRS), focal photocoagulation, a type of laser treatment, is being evaluated in patients who are still in the early stages of diabetic eye disease. Recent results from this study show that it is possible to halt or even reverse the visual loss that occurs in many people with diabetic macular edema--swelling in the small portion of the retina that provides sharp, central vision.

- The Diabetic Retinopathy Vitrectomy Study (DRVS) is a clinical trial comparing early vitrectomy with deferred vitrectomy in individuals with diabetic retinopathy who have suffered a vitreous hemorrhage. Vitrectomy is a surgical procedure for removing the blood which leaks from abnormal retinal vessels into the clear jelly-like material (the vitreous) inside the eye. This may induce scar tissue formation that can cause retinal detachment and ultimately lead to permanent vision loss or blindness. Investigators have found at two-year followup examinations in the DRVS that a higher percentage of eyes undergoing early vitrectomy recovered a 20/40 visual acuity than did the eyes in which the treatment was deferred in hope that the hemorrhage would clear on its own. The percentage recovering 20/40 vision was even higher in Type I (juvenile onset) diabetics. The investigators have concluded that early vitrectomy can improve changes of long-term recovery of good vision in some eyes.

- A multicenter randomized controlled clinical trial, the Branch Vein Occlusion Study (BVOS), was designed to document the natural history of this disease and to improve the management of--or prevent--its complications. This study has shown that peripheral scatter argon laser photocoagulation significantly reduced the development of neovascularization and the development of vitreous hemorrhage in treated eyes when compared to an untreated control group.

- The gene for an enzyme that has been shown to be deficient in patients with gyrate atrophy, a blinding deterioration of the retina of the eye which begins in childhood, has been isolated by NEI-supported researchers. Isolation of this gene will not only help scientists better understand the molecular basis of this disease but may also provide useful information for genetic counseling and the potential for development of gene therapy for this blinding disease.

- The impact of diseases affecting the macula--the part of the retina responsible for central, fine vision--will increase in the future as the number of aged people in our population increases. Major clinical studies have been and are being conducted to investigate treatments for types of macular disorders. Age-related macular degeneration (AMD) is the leading cause of severe visual loss among people age 60 and older. The Macular Photocoagulation Study Group has reported that argon laser photocoagulation treatment of newly formed abnormal blood vessels in one form of this disease is effective in preventing severe visual loss.

- This Study Group has also reported the results of the Ocular Histoplasmosis Study, the purpose of which was to determine whether argon laser photocoagulation would be of any benefit in preventing loss of visual acuity in eyes with evidence of ocular histoplasmosis and associated abnormal growth of new blood vessels. The results of a followup visit showed that 34.2 percent of untreated eyes compared with 9.4 percent of treated eyes lost significant visual acuity. Although recruitment for this study was terminated because more untreated eyes than treated eyes had experienced severe visual acuity loss, follow-up of patients continues to assess long-term treatment results.

- Two NEI grants have contributed to recent advances in locating genes for hereditary retinal degenerations. These investigators have confirmed and refined other investigators' estimates of the location of the gene for a form of retinitis pigmentosa, a blinding hereditary disease that strikes children and adolescents. This information may ultimately lead to the development of gene therapy for this disease.

- In diabetic retinopathy the uncontrolled growth of retinal vessels (neovascularization) may be due to the presence of growth factors at the cellular level. A recent discovery that vascular endothelial growth factors bind to heparin, a compound often used as an anti-coagulant, is an important breakthrough because it will allow scientists to purify these growth factors by binding them to heparin. Until the development of this methodology it had been difficult to purify angiogenic factors; but, now that this can be done quite easily, rapid progress in gaining an understanding of the neovascular process can be expected.

- The S-antigen, a molecular component of the photoreceptor cell, has recently been cloned and sufficiently purified to demonstrate its ability to trigger some forms of uveitis (a severe autoimmune intraocular infection). Scientists are now attempting to identify antigenic proteins other than S-antigen to test whether these antigens may also cause uveitis to develop in animal models.

- In research on developmental and hereditary retinal degenerations the application of molecular biological techniques to studies of retinitis pigmentosa and related disorders will continue in an effort to provide new insights into the genetics of these diseases and possibly to isolate the defective genes.

Present Status of Research Activities:

- In the past year the NEI has inaugurated a major clinical trial to evaluate cryotherapy as a method of halting the progression of a blinding disease of low-birth-weight infants (called retinopathy of prematurity) in severely affected children. In this procedure selected sites on the sclera (the white of the eye) is frozen with a cryoprobe, thereby altering the underlying retinal tissue and creating a barrier that prevents the abnormal growth of tissue and blood vessels that threatens to detach the retina.

- The relationship of genetic and nutritional factors to the retinal damage caused by light is also being explored in animal models with hereditary retinal degenerations. These studies may lead to a better understanding of hereditary retinal degenerative conditions such as retinitis pigmentosa and may ultimately allow the development of measures to prevent or retard the degenerative process and, in so doing, spare many people from the lifelong burden of visual handicaps acquired in childhood.

- Characterization and localization of antigens of specific retinal cell types--Müller and horizontal cells--are being attempted with monoclonal antibodies. These studies should yield information needed to determine the relation of these antigens to autoimmune diseases of the eye.

- A study is being conducted to measure intraretinal oxygen tension with microelectrodes because an adequate supply of oxygen to the retina is crucial to the maintenance of visual function. This will allow the development of a mathematical model of retinal oxygenation which may improve understanding of its role in the neovascularization that occurs in diabetes.

- The laser doppler technique is a noninvasive means of measuring blood flow rate at selected sites in the retina. It is being used to characterize quantitatively the retinal circulation of selected patients with diabetic retinopathy, to aid in diagnosis, to determine prognosis, and to monitor the effectiveness of therapy.

Priority Areas for Future Research:

- Continue to support clinical trials of treatments for retinal vascular diseases and test the efficacy of rigorous blood sugar control in the prevention of diabetic retinopathy.
- Isolate and characterize substances which lead to or inhibit uncontrolled blood vessel growth in the retina.
- Develop and improve methods for the definition and diagnosis of ocular inflammatory disease and for the determination of the role of the immune system in other ocular disorders.
- Utilize recombinant DNA technology to explore gene expression and basic mechanisms in ocular inflammatory disorders.
- Conduct molecular genetic studies to determine the nature of inherited predisposition to retinoblastoma and uveal melanoma.
- Determine through epidemiologic studies the risk factors which predispose to uveal melanoma, retinoblastoma, and other ocular malignant tumors and whether the incidence of these tumors is increasing.

- Develop methods to detect carriers of hereditary retinal degenerations and prenatal tests to identify affected individuals.

- Compare the metabolism of the macular region to other retinal regions to determine changes that occur with aging and identify factors that predispose the macula to disease.

- Determine changes in the retinal pigment epithelium associated with retinal detachment and reattachment and identify factors that stimulate photoreceptor regrowth and permit the pigment epithelium to return to normal function after reattachment.

Corneal Diseases

Significant Recent Accomplishments:

- A recent Tear Film Symposium sponsored by the NEI brought together researchers from the U.S. and abroad to discuss the current status of tear film research and therapy. The outcome of these deliberations has been renewed research activity in tear film composition and function and increased focus on research techniques to improve understanding of ocular surface problems.

- Because immune rejection of transplanted corneas is the leading cause of corneal graft failure, research is currently aimed at gaining an understanding of the rejection process and attempting to modify or eliminate it. Donated corneas that have been soaked in a solution containing antibody against the histocompatibility (human lymphocyte) antigens found on the surfaces of most tissues have been shown to have an increased survival rate when compared to unsoaked grafts.

- Herpes simplex virus (HSV) infection of the cornea is responsible for most corneal blindness in this country. Although an initial infection may subside after treatment, nearly 25 percent of those infected experience a recurrence of the epithelial disease or a complication of the infection in the stromal layer of the cornea within two years of the initial infection. Vision scientists have developed an in vivo experimental system for reactivating latent herpes simplex virus (HSV) infection from neural tissue, making it possible to study the process by which latent HSV infection becomes reactivated.

- Scientists have developed better reagents (monoclonal and polyclonal antibodies) and more elegant techniques to identify adenoviruses isolated from the ocular surface and from cell cultures. These technical advances have improved the rapidity and sensitivity of the detection of these viruses, which have been shown to cause a keratoconjunctivitis and cancer in laboratory animals.

- Tissue-cultured corneal endothelium and endothelium from the lining of blood vessels have been transplanted successfully in animals, resulting in a return of normal corneal endothelial physiological function, morphology, and clarity. Additional work still needs to be done before this procedure can be used in endothelial replacement and repair in humans.

Present Status of Research Activities:

- Scientists are investigating the observation that the surface of the eye seems to be more vulnerable to injury when there is nutritional vitamin A deficiency. Vitamin A deficient rabbits with corneal lesions similar to those found in children who are vitamin A deficient are being studied. In addition, clinical studies of such children in developing nations (where malnutrition is common) are now underway to define the mechanism responsible for the high incidence of blindness associated with measles and other infections.

- A six-center clinical trial, the Cooperative Corneal Transplantation Study, is being conducted in patients requiring corneal transplants who are at high risk of transplant rejection (that is, they have highly vascularized corneas or a prior history of rejection). These patients will be assigned corneas whose human lymphocyte antigens (HLA) most closely match their own.

- Several ongoing NEI-supported studies are designed to elucidate the mechanisms involved in the progression of HSV keratitis into latency or dormancy and the eventual reactivation of latent virus responsible for the recurrent disease.

- An improved method for delivery of antiviral drugs to the site of HSV infection is also being evaluated. Liposomes (minute lipid bound sacks) containing a variety of antiviral drugs which have specific antibody against HSV on the surface are being constructed. These immunoliposomes should attach specifically to virus-infected cells and allow the drug to diffuse from the liposome, creating a high local concentration of the drug for a prolonged period. This should inhibit viral replication close to the attachment site and reduce the frequency of topical administration required for effective treatment.

Priority Areas for Future Research:

- Increase investigations in ocular immunology which have recently contributed information on viral pathogenesis, and continue investigations aimed at developing herpes vaccines.
- Investigate immune responses to herpes simplex virus by recombinant DNA technology and isolate the genes involved in the pathogenesis of this virus.
- Use simian varicella virus as an animal model for human varicella-zoster infection of the eye.
- Evaluate new antiviral and antiinflammatory agents for therapy of ocular infections due to adenoviruses and other viruses.
- Establish diagnostic techniques and evaluate medical therapy for amoebic keratitis, a parasitic infection of the cornea.

- Investigate the cellular origin of various tear components using monoclonal antibodies.

- Develop innovative methods of drug delivery for treatment of ocular surface disorders.

- Develop improved contact lens designs and materials for correction of refractive errors.

- Study the biological effects of synthetic corneal implants for the correction of refractive errors.

- Define normal corneal development using modern technologies such as monoclonal antibodies and gene cloning.

Cataract

Significant Recent Accomplishments:

- The enzyme aldose reductase has been increasingly implicated in the etiology of diabetic complications. A decade of basic research on the formation of diabetic cataracts through the action of aldose reductase has not only paved the way for the development of drugs such as sorbinil, that inhibit the enzyme but has also opened other avenues of investigation into the role of aldose reductase in a variety of diabetic complications. Ongoing work should lead to a more precise understanding and control of the pathological effects observed in diabetes and be useful in designing anti-cataract drugs.

- Significant advances have been made in characterizing crystallin lens structures, and molecular studies on crystallin lens genes have been initiated. Crystallins are the lens proteins responsible for transparency. The cloning of crystallin genes in bacteria holds promise for further elucidation of protein and genetic activity in the lens.

- Recent experiments have also shown that a crystallin gene can be inserted into the chromosomes of mice, resulting in production of that crystallin in the lens of the mouse. This indicates that it is now theoretically possible to correct crystallin gene deficiencies that may be related to genetic cataracts.

- Dramatic progress has been made in developing nuclear magnetic resonance techniques to monitor changes in lens components noninvasively. These techniques offer the possibility of detecting changes in the lens well before the appearance of an opacity.

- Advances in molecular biology have made it possible to study the alteration of lens proteins and investigate the extent to which such alteration affects transparency. Studies have indicated that oxidation of protein and lipid components of the lens is related to the onset of senile cataract. A prime factor leading to this oxidative damage appears to be the ambient ultraviolet light radiation in sunlight.

Present Status of Research Activities:

- During the past year, the NEI initiated a case/control study of senile cataract in India. Senile or aging-related cataract is a major cause of blindness and visual disability throughout the world. The aim of this study is to evaluate associations of risk factors, such as nutritional status and family history, with major types of senile cataract and to evaluate methods of cataract classification.

- A number of researchers are using immunochemical and biochemical techniques to study lens components in normal and disease states. These studies include ultrastructural, biochemical, and immunological characterization of the zonular fibers--the elastic fibers which support the lens. Investigation of the normal state of these fibers will provide valuable information on the abnormal conditions which lead to lens dislocation as well as to presbyopia, the aging-related condition that requires the use of reading glasses in middle-aged people.

- Studies are ongoing in animals to evaluate the use of aldose reductase inhibitors in protecting against diabetic cataract development, arrest further cataract development, and promote a reparative process. In addition to aldose reductase, the roles of other sugar metabolizing enzymes are being studied during the development of diabetic cataracts in higher animals and people having adult-onset diabetes.

- The effect of aging on the lens fiber membrane, protein synthesis, and the accumulation of water-insoluble protein in normal lenses is being studied.

- Studies of human senile cataract and selenium-induced cataract strongly suggest that toxic oxygen metabolites, such as hydrogen peroxide, hydroxyl ions, or singlet oxygen, are triggering agents in the development of cataract. Attempts are being made to prevent or arrest cataract in animal models by using antioxidants.

- Investigations are in progress to increase understanding of the transport of inorganic ions and organic nutrients across cellular plasma membranes in the lens. Since the lens is dependent upon diffusion of nutrients from the aqueous humor, the fluid that circulates between the cornea and the lens, an understanding of this process may help to determine the clinical significance of deficiencies in transport which can develop during cataract formation.

Priority Areas for Future Research:

- Investigate the molecular biology of lens development and differentiation, with particular emphasis on gene cloning and analysis of lens gene organization and regulation.

- Develop nuclear magnetic resonance (NMR) and other noninvasive techniques to study the normal and diseased lens.

- Develop lens cell culture systems to study cell division, gene transfer and expression, the effects of drugs on ocular tissues, and lens metabolism.

- Initiate epidemiologic studies of cataract to determine environmental, nutritional, and genetic factors that may be involved in cataract development.

- Conduct longitudinal studies of genetic cataracts in families.

- Develop improved techniques of cataract management and treatment in infants and children, and determine the influence of aphakia on development of vision in this age group.

Glaucoma

Significant Recent Accomplishments:

- Lack of patient compliance with prescribed self-administered therapy regimens has been a major problem in assuring adequate treatment of glaucoma. To investigate this problem, an eyedrop medication monitor has been developed which electronically records the day and time of each medication administration. A significant percentage of patients who used this device in a study were found to have complied poorly with the doctor's instructions regarding dosage and frequency of administration of glaucoma eyedrops. This study has shown the need for improved education of patients in the proper use of their glaucoma medications and better follow-up of compliance.

o Understanding the physiology of the formation of aqueous humor, the fluid that circulates between the cornea and the lens, has increased through the development of aqueous fluorophotometry, a method for measuring aqueous humor flow. Studies using this method have already provided important information about the physiologic mechanisms of drug actions (particularly in humans), basic physiologic data on the diurnal rhythm of aqueous humor formation, and changes in aqueous humor formation in disease.

o Epidemiologic studies are underway to determine the risk factors for open-angle glaucoma, especially to evaluate possible racial differences in these factors. In population studies, blood pressure and body weight have been found to be positively correlated with intraocular pressure. Myopia has been demonstrated to be a risk factor for open-angle glaucoma. Epidemiologic evidence suggests that migraine is also a risk factor. A better understanding of the risk factors for glaucoma, developed through the use of modern epidemiologic methods, could well improve the clinician's prognostic ability, shed light on disease mechanisms, and perhaps point the way to earlier and better treatments.

o The use of cell culture methods has provided new opportunities to assess the role of trabecular cells (those which compose the trabecular meshwork in the front portion of the eye through which the aqueous humor flows out of the eye) in 1) maintaining normal outflow of aqueous humor from the anterior chamber, 2) alterations which may take place in different types of glaucoma, and 3) responses to drugs which influence aqueous humor outflow.

- Studies using light and electron microscopic analyses of human tissues obtained following well-documented clinical disease have aided understanding of the mechanisms by which the optic nerve is injured in glaucoma.

Present Status of Research Activities:

- The compound 5-fluorouracil, a chemical that inhibits cell proliferation, is being administered postoperatively under the conjunctiva of the eye in a randomized clinical trial. Administration of this chemical has been shown to enhance the success of conventional glaucoma surgery in high-risk patients by inhibiting scar tissue formation over the site of the tiny incision made to let minute amounts of aqueous humor leave the eye to lower intraocular pressure. The purpose of this trial is to define further the safety and efficacy of this treatment.

- Numerous previous studies supported by the NEI have documented the efficacy, relative safety, and potential risks of argon laser trabeculoplasty, a procedure that increases outflow of aqueous humor. A randomized clinical trial, the Glaucoma Laser Trial, is comparing the efficacy of this therapy with that of traditional medical treatment with topical drugs in the newly diagnosed patient with primary open-angle glaucoma.

- An attempt is being made to identify factors other than intraocular pressure which influence the susceptibility of an optic nerve to glaucomatous damage.

- The pathogenic process by which elevated intraocular pressure causes the death of retinal ganglion cells is being investigated. The potential causes for the increased susceptibility to glaucoma found in aged, myopic, and black people is also being examined.

- Attempts are being made to find an effective carbonic anhydrase inhibitor (CAI), a drug currently administered in tablet form used in the treatment of some cases of glaucoma, that could be applied topically to the eye instead, thereby reducing its numerous undesirable systemic side effects.

- A study is being conducted to assess the value of home tonometry (the at-home use of an instrument which measures intraocular pressure) in glaucoma patients and ocular hypertensives (individuals with elevated intraocular pressure who do not have glaucoma but may develop the disease). This study may serve to identify early those ocular hypertensive patients at risk for developing open-angle glaucoma and should enable physicians to treat glaucoma by prescribing optimal drug administration schedules to coincide with periods of elevated intraocular pressure.

Priority Areas for Future Research:

- Conduct epidemiologic studies to determine factors that place people at risk to glaucoma and why people lose vision due to glaucoma.
- Conduct a controlled clinical trial to evaluate treatment of ocular hypertension.
- Conduct clinical trials of new drug, laser, and surgical treatments for primary open-angle glaucoma.
- Exploit advances in transport physiology, immunocytochemistry, cell biology, and molecular biology to investigate local and intracellular mechanisms that govern aqueous humor formation and outflow.
- Develop new noninvasive methods for studying the pathophysiologic mechanisms of glaucomatous optic nerve damage in human eyes.
- Apply new techniques in immunocytochemistry and cell biology to study the optic nerve head in normal and glaucomatous eyes.
- Describe the pathogenesis of angle-closure glaucoma and subtypes of the disease.

- Search for and study populations with a high incidence of congenital gleucoma to improve understanding of the natural history of glaucoma and its treatment in children.

- Develop and evaluate new treatments for neovascular and inflammatory glaucoma.

Strabismus, Amblyopia, and Visual Processing

Significant Recent Accomplishments:

- Studies of animal models of visual development and abnormal visual experience have contributed immensely to the clinician's knowledge and understanding of the conditions seen in patients. By introducing the concept of the "critical period" in visual development, clinicians have been made more conscious of the importance of early diagnosis and treatment of their patients and of the need to study early visual development in infants. Recent clinical studies have centered on visual acuity and resolution and color perception in human infants.

- Recent innovations in molecular research techniques have been used to label neurons in the central visual pathways of normal and visually deprived animals to describe the effects of visual deprivation at the cellular level. The realization that, at least in lower vertebrates, neural connections can be broken and formed by different manipulations has led to new concepts about the conditions required for the stable transmission of visual impulses. This work has expanded our understanding of the cellular basis of visual impairment caused by strabismus (an imbalance of the eye muscles causing the eyes to turn in or out) and other visual sensorimotor disorders.

- A recent study has shown that adult retinal ganglion cells will regenerate injured axons for distances of several centimeters when they have been provided with a segment of peripheral nerve that has been grafted into the retina. This observation shows that peripheral nerves contain the necessary factors for regeneration that are not normally available to central nervous system neurons. These factors may include a suitable substrate over which to grow, as well as substances which serve to induce the alterations in gene expression that are necessary for axon growth. Identification of these factors may lead to the ability to stimulate the growth of new axons to replace those injured by disease or injury.

Present Status of Research Activities:

- Each year more than 80,000 people undergo eye muscle surgery for correction of strabismus. One of the major problems confronting the surgeon is determining how much correction is required to bring the patient's eyes into alignment. Because it is difficult for doctors to gauge this precisely, many children with surgically correctable strabismus have to undergo several operations before alignment is achieved. To improve presurgical assessment of children with one common form of strabismus, the NEI is supporting a multicenter clinical trial that will determine whether children slated for strabismus surgery are more likely to have a successful outcome if the doctor first performs a prism adaptation test to estimate the amount of surgical correction required to achieve permanent alignment. This method may greatly reduce the number of repeat operations required for the correction of strabismus.

- A significant number of Americans have irreversibly impaired vision. In 1980, the National Society to Prevent Blindness (NSPB) estimated that there were 11.4 million people with impaired vision in the United States; of these, 1.4 million had severe visual impairment and about 500,000 of these were legally blind. In response to the needs of these people, the NEI is supporting research on the assessment of functional vision. The goal is to develop a battery of tests that could be used by eye care specialists to generate a visual function profile for each of their patients and then predict how their functioning will improve with the use of specific visual aids.

- Severe myopia has been produced experimentally in infant tree shrews; the myopic eyes also exhibit abnormal and retarded lens development. A study is being conducted to test the hypothesis that the growth of both the lens and the eyeball is regulated by the visual information received during development.

- Recent evidence has shown that near work can modify the resting tonus or state of contraction of the muscles which alter the shape of the lens to focus an image on the retina (accommodation) and those which move the eyes to allow binocular vision. This may contribute to the development of myopia. The role of sensory processes and oculomotor tonus in the control of visual accommodation and binocular vision is being investigated.

Priority Areas for Future Research:

- Analyze the functions and mechanisms of action of molecules involved in central visual processing.
- Emphasize research to understand factors that facilitate regeneration of optic nerve fibers and guide them to connect to the proper region of the brain.
- Conduct neural transplantation research in mammals with the dual aims of eventually restoring lost visual function and, in the shorter term, learning more about the development of visual pathways in the brain.
- Use new imaging techniques, such as positron emission tomography (PET) or nuclear magnetic resonance (NMR), to localize lesions and test the functioning of specific parts of the visual system, especially "higher order" visual processing.
- Develop animal models of amblyopia that reflect the more subtle deficits in visual function often seen in humans.

o Investigate the development of the visual system at the molecular level using animal models.

o Identify, characterize, and define the function of neurotransmitters, peptides and other chemicals important in signaling between cells in the visual pathways and oculomotor systems.

o Describe at molecular, physiological, and anatomical levels the development of the oculomotor system.

o Elucidate the normal development of accommodation and convergence in human and nonhuman primate infants.

DEAF-BLIND SERVICES

WRITTEN TESTIMONY

SUBMITTED

TO THE

UNITED STATES HOUSE OF REPRESENTATIVES,

APPROPRIATIONS COMMITTEE

REGARDING

THE EDUCATION OF THE HANDICAPPED ACT

TITLE VI, PART C

CENTERS AND SERVICES FOR DEAF-BLIND CHILDREN

APRIL 7, 1986

SUBMITTED BY:

KEVIN J. LESSARD, DIRECTOR

MICHAEL T. COLLINS, SUPERVISOR

PERKINS SCHOOL FOR THE BLIND

175 NORTH BEACON STREET

WATERTOWN, MA 02172

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History

In the mid-1960's, the Rubella epidemic in the United States resulted in the birth of over 20,000 handicapped children, many of whom had multiple sensory deficits. In 1969, the Congress of the United States passed legislation which created Centers and Services for Deaf-Blind Children, under Public Law 91-230 (Title VI; Part C). During the next decade, Regional Centers for the deaf-blind grew and expanded, resulting in the identification of over 5,000 deaf-blind children nationwide. Using federal funds as incentive and as "seed" monies, direct services were established in every State in the Nation. Over this same period of time, the Federal funding level increased to a maximum of $16 million, and this level has remained somewhat stable for the past six (6) years.

Up until the passage of Public Law 94-142, the Federal funding effort primarily provided basic direct services to the deaf-blind population nationwide, and technical assistance and inservice training to program staff and students' families. Since the advent of P.L. 94-142, basic services have been largely provided by States and local educational authorities. During this transition period Title VI-C funds have continued to provide supplementary direct services to the identified deaf-blind population in this country. Such needed services have included: the improving of instructional ratios above State mandatory education requirements; the hiring of consultants for programs who have specific skill contributions, such as vision training, language specialists, mobility training, and clinical therapies; the provision of respite care services; the expansion of vocational training; and the implementation of creative transitional services for the "aging out" population as they prepare for adulthood.

For this next Fiscal program year, the United States Department of Education/Special Education Programs is stipulating that no funds allocated to single State or Multi-State Centers may be used for direct service to the "school-age" deaf-blind population in each State, and that all funds must be used for either direct services to non-mandated age groups or technical assistance to States. In other words, the direct services which were allowed permissively by P.L. 98-199 are being regarded as superfluous and are therefore, being disallowed by Special Education Programs. This brief synopsis does not do complete justice to the complex evolution of a small, discreet program for a highly complex and complicated population, but it brings us to the present issues, to which we would like to testify:

1. Proposed budget cuts for 1985-86, and 1986-87

Within President Reagan's FY '87 Budget, submitted to Congress on February 5, 1986, the following is recommended for the Title VI-C program:

FY '86 Appropriated:	$15.00 M
FY '86 Appropriated With Sequester:	$14.35 M
Recommended FY '86 Level to Absorb '87 Impact:	$12.00 M
FY '87 Presidential Request:	$ 9.00 M

Please note that this plan represents a 20% reduction in deaf-blind services for the duration of this year (FY '86), and a total of a 40% reduction for FY '87. These reductions are far in excess of the anticipated sequester amounts and far in excess of the majority of anticipated handicapped services reductions. We recommend that the sequester for FY '86 affect all programs more proportionately rather than penalizing one small program so heavily. The 1986 recommendation appears to take unfair advantage of the fact that the deaf-blind population is a relatively small and not-so-vocal minority.

It is our understanding that the Administration is recommending such drastic cuts on the following basis: because the program's emphasis is now upon technical assistance, and not direct services, consequently technical assistance is less expensive to deliver. This is unfounded logic, based on an assumption that direct services from the Federal government are no longer needed. We have addressed this need in issue #3 on page 5. In short, the Department of Education has prohibited use of the funds for direct service and is using this action to then justify an extreme funding cut.

Another concern of ours relates to the thinking that, to better prepare the population for a reduction of $6 M in services next year, we should take away $3 M of these services this year, thus "making it an easier transition." The reductions in service as they occur to meet the demands of Gramm-Rudman will be difficult enough. We think it is unfair to reduce the services earlier than necessary in order to prepare people for the reduction. Staff in our profession have a much different orientation, to offer as much as we can to the deaf-blind population for as long as our time, energy, and resources allow.

2. An emphasis on directing funds away from the deaf-blind population in 1986-87

For the next Fiscal year, 1986-87, the Department of Education has issued an RFP which, for the first time, allows for the use of Title VI-C funds for other than deaf-blind students. Please note that of the total anticipated $15 million allocation, $5.437 million is being eliminated from deaf-blind services and diverted to "demonstration projects for the severely handicapped, which may include deaf-blind persons." These demonstration projects are expected to be funded at an average of $100,000 each, annually. In the past, if one applied for a deaf-blind demonstration project, one was required to serve only deaf-blind children with these funds. Under the new guidelines, one could receive a $100,000 grant to serve 20 children, only 2 of whom are deaf-blind. Thus, the majority of the funds would be used to support handicapped populations other than the deaf-blind.

This significant change within the guidelines of the Office of Special Education clearly means that, of the potentially available $15 million for deaf-blind children, over 33% of the $15 million is being diverted into such demonstration projects with no controls on the representation of deaf-blind persons within these projects.

The following chart clearly emphasizes this particular point:

Projects Specific to Deaf-Blind	1985-86	1986-87	Change
Single & Multi-State Centers	$8.3 M	$4.9 M	-41%
T.A.S.H. Tech. Assistance	1.0	1.0	-
Helen Keller Tech. Assist.	.7	.7	-
Deaf-Blind Model Demo. Projects	5.0	1.0	-80%
Deaf-Blind Nondirected Projects		1.96	
Total Specifically Deaf-Blind	$15.0 M	$9.563 M	-36%
Demonstration Projects for Severely Handicapped (Including Deaf-Blind)		5.437M $15.0 M	(Total Amount Being Diverted to Severely Handicapped Projects)

It is our contention that the original authorization of Title VI-C and later reauthorizations have all occurred with the intent that funds be appropriated to serve deaf-blind individuals. Such redirection of the use of this funding, as stated above, seems to be in conflict with the intent of Congressional action. Any needed appropriations for other severely handicapped children are not disputed but should not be funded by redirection of funds from deaf-blind children.

In addition, the deaf-blind population's needs have not been eliminated or reduced to a point where such redirection of funding is warranted. Although the incidence of maternal rubella syndrome has greatly declined, the incidence of children being born with deaf-blindness is remaining constant. Etiologies have changed but the need for specialized services to meet the unique needs of deaf-blind children have not changed significantly. The data on the deaf-blind population in 5 New England States shows a constant incidence of the population, and this data is confirmed by statistics available from other States and Regions. (See Appendix A).

3. The elimination of direct services to the school-aged population in 1986-87

The deaf-blind population is a complex low-incidence population with a multitude of varied needs, as evidenced by the dual sensory deficits in combination with varying degrees of retardation, intelligence, emotional problems, and other physical disabilities. Due to these complex needs, the cost of direct services can range from $15,000 to over $50,000 per capita annually. These costs are obviously substantial costs for a local community or individual States to incorporate into their Special Education budgets. To date, the flexibility of using VI-C funds to add to the local community's contribution has made the financial burden more tolerable for these communities. It should be noted that the United States government funding level accounts for not more than $2800 per child nationally, an extremely small portion of the total direct service costs. It has been stated by the United States Department of Education that there should be no Federal role in the providing of direct services to a school-aged population, since all States have reasonable comprehensive mandatory special education laws which require free, appropriate public education. In theory, this point seems to be valid, inasmuch as these State laws do exist. However, in practice, the quality of services to the deaf-blind population continues to be adversely affected, for the following reasons:

a) Unlike the Federal effort, many States do not have legislation or appropriations which recognize the unique needs of the deaf-blind population, per se. Consequently, these students do not become identified as deaf-blind or their special needs go unidentified;

b) There are variations in States' mandatory special education laws, ranging from a requirement of minimally adequate services to the student's right to a program where he or she can progress to the maximum extent. Consequently, services to deaf-blind children in some States are only minimally adequate.

In recent years, VI-C funds have been used to provide creative and innovative direct service to the population including vocational programming, supported work, transitional planning, total life planning, and training for community living. These are not basic or core educational services which local communities always provide comprehensively under a traditional Individual Education Plan. They are frequently supplemental to the typical school program, but essential to deaf-blind individuals. It is our contention that funds for direct services for deaf-blind students need to continue for the above reasons. The Federal role in direct service provision to the population is a small but extremely important component in assuring deaf-blind children quality and comprehensive educational services.

Summary

In summary, we are asking that the following actions be taken:

1. Regarding the Reagan Administration's proposed reductions in the 1986 and 1987 Budgets for deaf-blind services:

   We are imploring the House Approriations Committee to please assure that these funding levels be increased to the FY '85 $15.3 million level. Any funding reductions should be proportionate to those which other handicapped populations will be experiencing.

2. Regarding the Department of Education's permitting of VI-C funds to be used to serve children who are not deaf-blind:

   We are asking the House Appropriations Committee to clarify its position on this dramatic shift and to please assure that funds which have been appropriated for the deaf-blind population be used to only serve the target population.

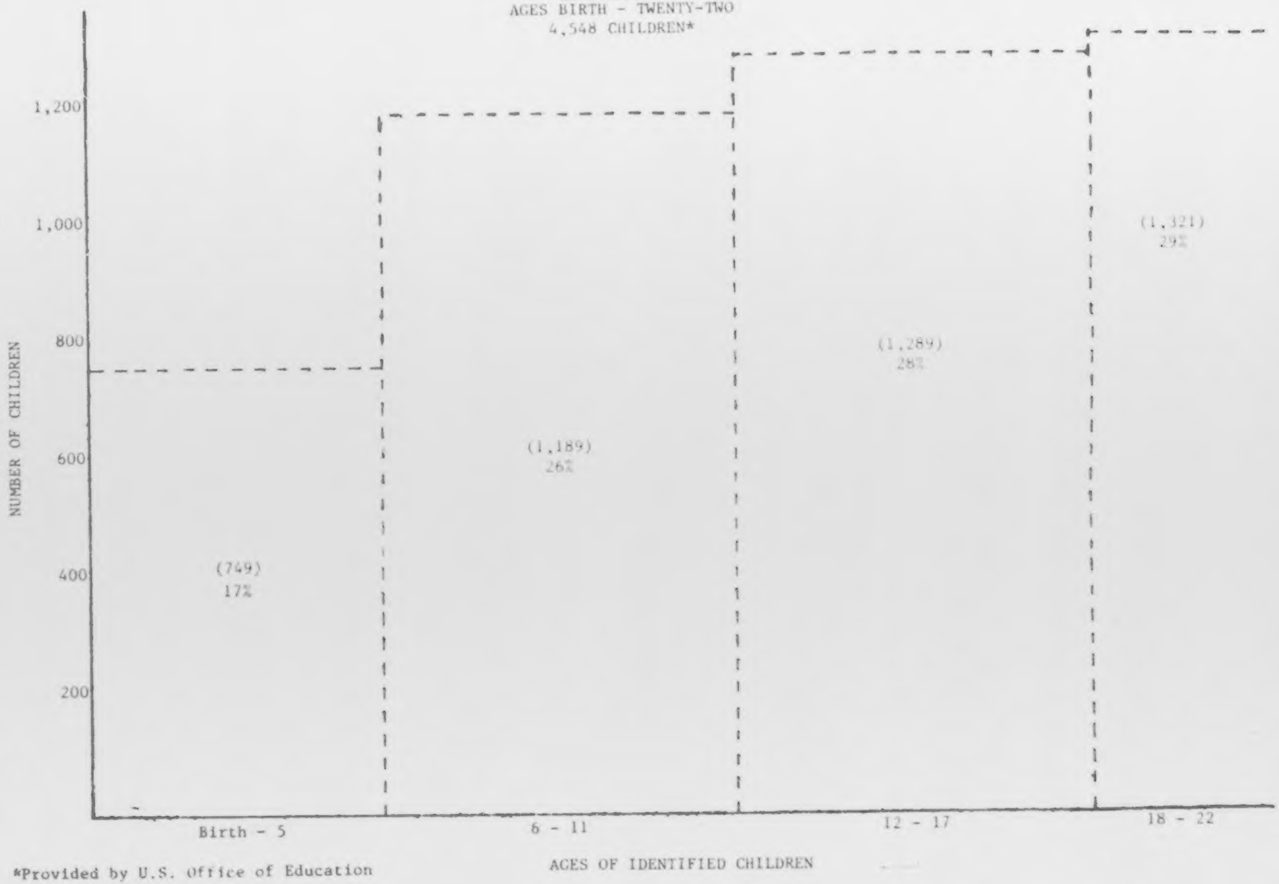
3. Regarding the Department of Education's elimination of direct service to the school-aged deaf-blind population:

   We are asking the House Appropriations Committee to issue a directive reinstating direct services to the deaf-blind children who are in need of such direct services according to documented need.

We will gladly provide additional information or data as needed, and we will make ourselves available to you as you deem necessary.

We thank you for your time and attention and we appreciate your support for a future program for deaf-blind children which is meaningful and effective, and a program that best meets the needs of deaf-blind children and their parents.

DEAF-BLIND CHILDREN
NATIONAL DATA
AGES BIRTH - TWENTY-TWO
4,548 CHILDREN*



*Provided by U.S. Office of Education
February 1986

STATEMENT OF CHRIST PETROULEAS, CHAIR, NATIONAL COLLEGIATE ATHLETIC ASSOCIATION NATIONAL YOUTH SPORTS PROGRAM COMMITTEE, BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

April 30, 1986

Mr. Chairman and members of the Subcommittee, my name is Christ Petrouleas. I am the Chairman of the National Collegiate Athletic Association's National Youth Sports Program Committee. I have been involved with the program since 1969 and have served on the national committee for six years. I appreciate this opportunity to submit this statement in support of an appropriation ~~of \$6.13~~ million for the FY 1987 NYSP.

We recognize that this is a year in which budget constraints are, once again, severe. Yet we believe that the NYSP deserves your continued support. The need for the program continues because of the persistence of urban and rural poverty and because of cutbacks in and eliminations of other programs serving disadvantaged youth. The NYSP is a high-quality program which makes effective use of federal dollars in providing vitally needed services.

During the long, hot summer the NYSP gives more than 55,000 disadvantaged boys and girls, ages 10-16, a chance to participate in organized athletic and educational activities in the setting of nearby college campuses. Programs in 1985 operated at 141 sites in 45 states and 122 cities. Through sports instruction and competition, young people learn about their human potential; through this exposure to the educational component of the program, they learn to broaden that potential.

From its beginning in 1969, the NYSP has made a special effort to target "high risk" youth for participation in the program because those children are the ones most likely to benefit from educational and enrichment component. Projects in Detroit, Chicago and Baton Rouge, for example, ask school principals, probation officers and youth home directors for help in identifying individual youngsters who should be encouraged to participate. There is concrete evidence that this approach is working: police officials in Los Angeles, Denver and Dayton, for example, have acknowledged reductions in gang activity and other disturbances, as a result of the NYSP projects in those communities.

Our funding request for the NYSP is the same as it was for the last two years and substantially the same as it has been since 1976, when the funding was $6.0 million. However, despite the relatively flat federal funding level, the program has grown over the years and continues to provide high-quality services to program participants. We have been able to do this because the NCAA has actively sought assistance from state and local governments and from the private sector for the NYSP. In 1985, the federal funds were matched on nearly a two-to-one basis by funds from these other sources.

In fact, voluntarism has been the key to the NYSP's success. In 1985, the NCAA expended an estimated $310,000 of its own funds for NYSP management and we expect that it will spend about $326,000 in 1986. In last summer's program, the 141 participating institutions provided facilities, equipment and services valued at more than $8.3 million. Businesses and state and local governments contributed an additional $2.4 million. For the 1986 program, the Spalding Corporation is expected to make a grant of $105,000 to be used for the purchase of T-shirts for project participants, and to contribute basketballs for every project; the NCAA identified additional corporate sponsors whose donations will benefit the program. Locally, many institutions receive support from area businesses in the form of grants, equipment and clothing or project awards.

No Federal funds are allocated to the NCAA or individual institutions for administration of the grant. The NCAA donates its assistance as the administrator of the NYSP. Ruth M. Berkey, NCAA Assistant Executive Director, serves as National Program Director and she is assisted by others on the NCAA staff. Policy decisions are made by the NYSP Committee, which is composed of five representatives from NCAA members or allied institutions and three ex-officio members representing the Federal government. Members of the Committee volunteer their services.

This unique combination of voluntarism and federal, state, local and private funding assistance allows the NYSP to provide a variety of valuable services. The highly trained staff at each project (typically serving about 400 youngsters) conducts a rigorous program of sports skill instruction and competition in a minimum of least three major sports for each participant. The participant-staff ratio of about 15 to 1 ensure each youngster personal contact with people who can serve as positive role models.

The NYSP also provides an enrichment program in recognition of its philosophy that body and mind must be nurtured together. A central part of that program is counseling in drug and alcohol abuse prevention. In addition, participants are instructed in career and educational opportunities, job responsibilities, personal health and nutritional practices. Institutions are encouraged to offer additional enrichment programs and to have unique offerings which draw upon the outstanding educational and cultural resources available on the college campus and the surrounding communities.

Another program benefit is the free medical examination each NYSP student receives before participating in the program. Efforts are made to secure medical services for free or at a nominal cost to the program. Each participant is entitled to receive free medical treatment for injuries sustained while participating in the project. Each participant also receives a daily USDA-approved meal and snack. Eligible institutions receive USDA assistance for this purpose.

We work each year to improve the program and its management. In 1984, the NYSP Committee completely reviewed and revised the NYSP guidelines, operations manual and financial reporting system. Implementations of these changes and on-going quality and fiscal review took place in 1985. All projects also receive an annual review, which includes an on-site review and written evaluation. Financial reporting is monitored with a program of sample auditing. Institutions in need of management help are provided technical assistance and all new participating institutions receive on-site technical advice. Institutions unable to meet the NYSP's high standards are culled out and replaced by others better able to perform the mission.

This year, the NYSP will have behind it the NCAA's 17 years of experience in NYSP administration and 80 successful years of athletics administration. NCAA members and other institutions of higher learning provide to the NYSP some of the finest athletic facilities in the world. We know of no other organization that can mobilize the quantity or quality of resources applied to this program.

We are all acquainted with the severe budgetary pressures the Congress is confronting. Many programs formerly available for young people in the summer months have been reduced in scope or have disappeared entirely. The need for effective programs, such as the NYSP, thus becomes more critical each year. In the past, Congress has been generous with assistance to this program. On behalf of the children who have participated in the NYSP and on behalf of the NCAA, I extend our sincere thanks and ask that you recommend an appropriation of $6.13 million for the National Youth Sports Program.

ASSOCIATION FOR VITAL RECORDS AND HEALTH STATISTICS

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STATEMENT

OF THE

ASSOCIATION FOR VITAL RECORDS AND HEALTH STATISTICS

TO THE

UNITED STATES HOUSE OF REPRESENTATIVES
LABOR, HEALTH, AND HUMAN SERVICES, AND EDUCATION
APPROPRIATIONS SUBCOMMITTEE

ON THE

PRESIDENT'S PROPOSED FY 1987 BUDGET

FOR THE

NATIONAL CENTER FOR HEALTH STATISTICS

May 1, 1986

An Affiliate of the Association of State and Territorial Health Officials

The Association for Vital Records and Health Statistics represents health statistics programs in state and local health departments. We are affiliated with the Association of State and Territorial Health Officials, which shares the concerns presented in this statement.

We would like to highlight some issues related to the budget of the National Center for Health Statistics. NCHS is the primary health statistics agency in the federal government. Its responsibilities include collecting and analyzing data that are critical to maintaining and improving the health of our citizens. Some examples are the National Vital Statistics System, from which we get information about the natality and mortality experience of our population; the National Health and Nutrition Examination Survey, which provides data on nutritional and physiological health in the United States; the National Health Interview Survey, a principal source of information on the health, illness, and disability status of the population; and the National Ambulatory Medical Survey and the National Hospital Discharge Survey which provide information on the utilization of health care services.

Of these, the vital statistics produced by NCHS are the most fundamental. The National Vital Statistics System is the single most important data base for assessing the health of the United

States population. It is used to monitor health problems such as infant mortality, teenaged suicide, incidence of low birthweight, heart disease and cancer mortality. This system provides the Census Bureau with data necessary for making population estimates and projections. It is also essential to medical research and is a major source of data for the National Cancer Institute and the other institutes of health.

The National Vital Statistics System is a cooperative effort between federal and state governments. Data are collected by states, processed, and provided to NCHS, in computerized form, under contract. Payment for vital statistics data is effected through a mutually agreed upon formula, which provides for the equitable distribution of funds among states. The formula is based on the philosophy that costs in the Vital Statistics Program should be shared between the states and the federal government. NCHS has stated that the federal government should fund at least 33 percent of costs directly related to the production of the state data tape, as determined by the formula.[1] The House Committee on Energy and Commerce shares NCHS's view of the appropriate federal funding share,[2] as do the National Committee on Vital and Health Statistics,[3] the Office of the Assistant Secretary for Health,[4] the Association of State and Territorial Health Officials,[5] and our organization.[6]

Despite the fact that NCHS has managed to maintain level funding (in current dollars) for the Vital Statistics program, increased costs in state offices have caused the funding share supported by the federal government to decline from over 40 percent in the late 1970's to the current level of 26.5 percent. The projected FY 1987 share of approximately 25 percent continues this decline in the federal level of support. Thus, over the past several years, the states have experienced a significant (34 percent) reduction in funding.

The impact of these funding reductions on state vital statistics programs is considerable. Without adequate funding, states must make programmatic cuts, including staffing reductions. These cuts will affect their ability to provide data that meet NCHS's contractual standards. As this situation continues over time the problem becomes more acute. Ultimately, if the federal share continues to decline, states may be forced to drop out of the Vital Statistics System. Alternatively, in order to retain states in this voluntary system, NCHS may find it necessary to reduce the scope of work in the vital statistics contracts. That is, NCHS may not be able to purchase all of the data it currently obtains under these contracts. In either case, there will be a loss of critical information: data from individual states may be missing, or whole data sets (e.g., deaths, marriages), and/or data items (e.g., race, ethnicity, prenatal care) may not be available at all. Thus, at a time when the nation needs quality data to make informed decisions, there is a very real potential that the needed information may not be available.

The recent Gramm-Rudman-Hollings sequestrations have already had adverse effects on the vital statistics program. When NCHS was required to cut $2.0 million from its FY 1986 budget, the only major block of uncommitted funds was in Vital Statistics. Thus, NCHS absorbed $1.7 million of its Gramm-Rudman-Hollings cut by reducing the period of performance on many state Vital Statistics contracts from one year to six or nine months.

In recent months, health professionals have urged NCHS to expand the Vital Statistics System into two new areas: the linkage of birth and infant death certificates to enable more intensive analysis of infant mortality, and increased analysis of occupationally-related mortality. Several Congressional Subcommittees have also expressed interest in these activities. While states recognize the importance of these efforts, and would like to participate, we have difficulties expanding the Vital Statistics System at a time when the funding base for the current program is eroding.

NCHS is an organization with responsibility for a variety of important public health data systems. It must balance its resources among those programs. We in the states recognize this and do not want to see funds diverted within NCHS from one important program to another. However, we believe that the Vital Statistics program is the most important of NCHS's activities. In the face of budget stringencies, even this most fundamental program is in trouble.

The proposed FY 1987 budget does not contain sufficient moneys to enable the states to continue providing vital statistics data to NCHS at their current level of effort. We continue to fall further and further behind in achieving the recommended federal funding level. To prevent the decline of the national vital statistics program we urge you to support the President's budget request which gives NCHS an additional \$2.3 million primarily to replace the FY 1986 sequestration. We also urge you to provide NCHS with an additional \$2.0 million to bring the federal share to approximately 33 percent of data acquisition costs. This is a small amount of money in the context of the federal budget. However, even though it is small, we ask you not to overlook it because of the major impact the Vital Statistics System has on all public health programs.

REFERENCES

1. Report of the Working Group on the Completion of the Vital Statistics Cooperative Program, DHHS, May 21, 1982.

2. House Report 98-818, pg 8, June 4, 1984. (Report of the House Committee on Energy and Commerce to accompany HR 5496, the reauthorization of NCHSR and NCHS.)

3. Report of the National Committee on Vital and Health Statistics to the Assistant Secretary for Health on the Vital Statistics Cooperative Program, September 20, 1984.

4. Letter from James F. Dickson III, M.D., Acting Assistant Secretary for Health, to Robert H. Barnes, M.D., Chairman, National Committee on Vital and Health Statistics, January 17, 1985.

5. ASTHO endorsement of AVRHS Resolution 85-4, March 3, 1986.

6. AVRHS Resolution 85-4; on the Report of the United States National Committee for Vital and Health Statistics on the Cooperative Health Statistics Program, August 16, 1985.

Testimony Presented
to
The Subcommittee on Labor, Health and Human Services
of the
U.S. House of Representatives Committee on Appropriations
on
April 30, 1986
2:00 p.m.

by

Meldon E. Levine
Congressman, 27th District, California
and
Samuel M. Genensky, Ph.D.
Executive Director
The Center for the Partially Sighted
Santa Monica, California

Mel Levine

Mr. Chairman and Subcommittee members, it is with great pleasure that I present to you a man of extraordinary talent and courage, a constituent of mine whose reputation is one that I have known for a number of years, and whose work I have come to know very, very well in the recent past, Dr. Samuel Genensky.

Dr. Samuel Genensky and I again come before you to urge the establishment and operation of a national information, referral, and training center for the partially sighted.

In 1984 there were 2.11 million partially sighted Americans. Approximately one-fifth of them were classified as legally blind. Further, more than three-fourths of the nation's 551 thousand legally blind have useful remaining sight.

Historically, and unfortunately even today, all too often partially sighted people are either offered no help at all or are offered services that are at best suitable for the totally blind.

For the past eight years Dr. Genensky and his colleagues at The Center for the Partially Sighted in Santa Monica, California, have offered the partially sighted of Southern California a viable alternative to blindness. They have helped these people to use all of their remaining sensory capabilities, including their precious residual vision augmented with appropriate visual aids, to function as visually and as independently as possible within the framework of fully sighted society.

Dr. Genensky is himself severely partially sighted and has been since someone in the hospital in which he was born mistakenly put potassium or sodium hydroxide in his eyes thinking that it was silver nitrate. More than 70 percent of the legally blind see better than he does. Yet he has always been a sight-oriented person. With the help of a pair of binoculars but without the use of a cane, guide dog, braille, readers, or any other visual substitution device or technique, he earned a bachelors degree in physics, magna cum laude, from Brown University, a masters degree in mathematics from Harvard University and a Ph.D. in applied mathematics from Brown University. He was a research mathematician on the staff of the Rand Corporation in Santa Monica from 1958 to 1978 and is the executive director of The Center for the Partially Sighted in Santa Monica, which he and his colleagues founded in the period 1976-1978. He has written many professional papers and has received numerous awards for his work on behalf of the partially sighted.

It is a special privilege and honor for me to bring Dr. Genensky to your subcommittee. His work, and he himself, have received the highest degree of praise from bipartisan political leaders in California and as well as from a cross-section of citizens throughout the State of California, and it is with a great deal of pleasure that I bring him to your subcommittee.

Testimony Presented

to

The Subcommittee on Labor, Health and Human Services

of the

U.S. House of Representatives Committee on Appropriations

on

April 30, 1986

2:00 p.m.

by

Samuel M. Genensky, Ph.D.

Executive Director

of

The Center for the Partially Sighted

Santa Monica, California

Thank you, Congressman Levine. It is a distinct pleasure and honor to join you in urging this distinguished Committee to establish and fund a national information, referral, and training center for the partially sighted. I say this because it has been shown that when partially sighted people are provided with appropriate low vision visual aids, are trained in the use of those aids and have the will to utilize them, nearly all of these people, including those who are also legally blind, can cope successfully with many sight intense tasks. Those tasks include (1) reading ordinary ink printed material, (2) writing with a pen or pencil, (3) moving about alone in even unfamiliar places without the help of a guide dog, a cane or a fully sighted guide, and (4) yes, viewing a chalkboard and taking notes from that chalkboard. This has been our experience at The Center for the Partially Sighted. It has also been the experience at the few other comprehensive visual rehabilitation centers in our country, and at low vision optometric and ophthalmological clinics and in private optometric and ophthalmological low vision practices. Thus I believe it is fair to say that the vast majority of the partially sighted, and yes, the vast majority of the legally blind, are not blind.

Further, my own research has shown that very few partially sighted people, including those who are also legally blind, will ever become functionally blind, that is will ever have to live as if they were totally blind.

Unfortunately, there are all too few persons and organizations that currently offer partially sighted people services that permit and encourage them to use their remaining eyesight, together with appropriate visual aids, to enter, re-enter, or remain within the world of the fully sighted. There are even fewer people and organizations that offer partially sighted people services such as individual, family, and group counseling; orientation and mobility training; and independent living skills instruction that recognize the value of remaining eyesight and that encourage and foster its use by the partially sighted.

The national center that Congressman Levine and I are urging you to bring into existence will:

1. Collect and disseminate referral information concerning existing low vision care, including comprehensive centers, low vision clinics, and competent individuals who include low vision care in their private ophthalmological and optometric practices;

2. Collect and analyze patient data obtained by our Center and other low vision facilities in order to derive information that would be of value to researchers, service providers, and the partially sighted themselves;

3. Provide advice, guidance, and assistance to qualified individuals and organizations that desire to establish and operate low vision facilities;

4. Provide fund-raising counsel that emphasizes the acquisition of support from the private sector and thus reduces the necessity of dependency upon scarce tax dollars;

5. Inform and sensitize professionals and paraprofessionals who work with or who are interested in working with the partially sighted as to their special needs and how they differ from the fully sighted and the functionally blind, the problems they tend to encounter, and possible solutions to those problems;

6. Provide information and guidance to partially sighted individuals and their families and the general public regarding the points cited in Item 5, and including information about various visual diseases, their prognoses and

their prevalence; low vision visual aids and their value; and information as to where partially sighted people can obtain various types of services; and

7. Train professionals and paraprofessionals (including, for example, ophthalmologists, optometrists, clinical psychologists, orientation and mobility instructors, independent living skills instructors, rehabilitation counselors and teachers of the visually handicapped) to bring their special skills to bear to help their partially sighted patients/clients to better understand their visual status. As part of that understanding, it is important for partially sighted people to know that partial sightedness is profoundly different from functional blindness, that residual vision has value, and that when it is used together with appropriate low vision visual aids, it can permit them to perform visually intense tasks that are important to them and that they could not otherwise cope with successfully because of their limited eyesight.

Appendices A and B indicate current Center national activities in these areas. Appendix A details recent staff networking and outreach presentations, and Appendix B lists training and technical assistance activities.

At The Center for the Partially Sighted in Santa Monica we have shown that services can be provided on an outpatient basis at significantly less cost than at state run or funded agencies that operate in residential settings and that emphasize visual substitution rather than visual enhancement. For example, in FY 1983-84 the cost per new patient served at our Center ran between 7.2 and 16.7 percent of what it would have cost to serve these same people at three distinguished state operated or funded residential facilities, and in FY 1984-85 those percentages ranged between 8.3 and 19.8 percent. (Please see Table 1.)

Further, at our Center we have also shown that although federal funding was needed to establish and initially operate the Center, we were able to obtain state and private funds to continue our operations when federal support disappeared in 1980-81. I believe that the proposed national center should be encouraged to seek private funding to begin, say five to seven years after it is established and operating. However, I anticipate that it will continue to need some federal financial support throughout the following years because the private sector is not able to underwrite all of the cost of such a facility and because state support cannot be expected due to the national scope of the proposed center. Table 2 contains a five-year estimate of operating costs for a national information, referral, and training center.

You may ask how we know that there is a need for a national center. We know the need exists. For example, in response to two items from our Center in Modern Maturity magazine in 1982 and 1984, our Center received over 11,000 requests for help from all over the nation. Table 3 gives a geographical breakdown of 3,575 inquiries received during the last eight months of calendar 1984. Each time our Center has media coverage, either in print or on radio or TV, we receive phone calls and letters from people who are desperate for help and guidance for themselves or their visually impaired loved ones. Appendix C contains a small sampling of recent letters requesting assistance.

It should be noted that every request for help is answered, and when appropriate, we refer the writer to the nearest source of quality care that is known to us. Unfortunately, in all too many cases that care is located hundreds of miles from the partially sighted person. The need is great and the resources are small, but the dedication of the relatively small number of professionals in the field is limited only by our limitations as human beings.

In summary, when the proposed national information, referral, and training center is established and operating, we can look forward to it:

(1) providing information and referral services to more than 94 percent of our nation's visually impaired and more than 76 percent of our nation's legally blind that will lead to their receiving services at significantly less cost per patient served than would be the case if these same people were served by organizations and agencies that would treat them as if they were totally blind; and

(2) training and professionals and paraprofessionals to be sensitive to the special needs of the partially sighted, and to bring their particular skills to bear in working successfully with visually impaired persons who have useful remaining sight.

Table 1

Funding and persons served or projected to be served by OCB, VIP, LSC & CPS in FY 1983-84 and FY 1984-85 and the ratios of cost per new client served at OCB, VIP and LSC to the cost per new patient served at CPS

	FUNDING FY 1983-84	PERSONS GOING THROUGH PROGRAM	FUNDING FY 1984-85 (ACTUAL OR PROJECTED)	PERSONS GOING THROUGH PROGRAM (ACTUAL OR PROJECTED)
OCB	$1,428,000	82	$1,466,000	84
VIP	510,804	65[1]	510,804	70[2]
LSC	232,989	31[3]	232,989	22[4]
CPS	690,100[7]	551[5]	790,000[8]	547[6]

	FY 1983-84	FY 1984-85
OCB/CPS	13.90 to 1[9]	12.08 to 1[9]
VIP/CPS	6.27 to 1[9]	5.05 to 1[9]
LSC/CPS	6.00 to 1[9]	7.33 to 1[9]

OCB - Orientation Center for the Blind, Albany, CA
VIP - Vocational Independence Program, Los Angeles, CA
LSC - Living Skills Center, San Pablo, CA
CPS - The Center for the Partially Sighted, Santa Monica, CA

[1] - This number represents the number of people in the residential program in FY 1983-84. One hundred clients were interviewed to determine their eligibility for the residential program, and 62 clients were given placement services only.

[2] - This number represents the number of people who were projected to be in the residential program in FY 1984-85. One hundred clients were projected to be interviewed for the residential program. No estimate was given as to how many clients were expected to receive placement services only.

[3] - In FY 1983-84 an additional 44 clients were given community resource assistance outside of the residential program at the LSC relative to family conferences and advocacy.

[4] - In addition, it was estimated that some 60 clients were to receive community resource assistance outside of the residential program at the LSC during FY 1984-85.

5- CPS gave services at its facilities to between 650 and 750 unduplicated patients in FY 1983-84. All new patients went through the standard program, and continuing patients received one or more of the following services: an annual or semi-annual low vision check-up; individual, family or group counseling; orientation and mobility training; and direction regarding other community services. In addition, the Center provided indirect assistance by phone and mail to more than 7,000 partially sighted people who live elsewhere in the nation.

6- It is estimated that between 650 and 750 unduplicated patients came to CPS for assistance in FY 1984-85, 547 of whom were new patients. In FY 1984-85 the CPS program was expanded to include training in independent living skills, in addition to those direct and indirect services offered in 1983-84.

7- The total expenditures of CPS in FY 1983-84 were $690,100; 54.4 percent of these expenses were met via gifts and donations from private individuals, foundations and corporations and an annual fund-raising dinner-dance known as the "Night for Sight," 27.5 percent via the $190,000 grant from the state of California, 9.1 percent via patient fees and the sale of visual aids, 6.7 percent via a federal research grant from the Administration on Aging to study peer volunteers in service delivery, 1.5 percent via a grant from the city of Santa Monica, and 0.7 percent via interest on monies in banks and certificates of deposit.

8- The total expenditures of CPS in FY 1984-85 were $790,000, 51.3 percent of which was met via gifts and donations from private individuals, foundations and corporations and an annual fund-raising dinner-dance called the "Night for Sight," 37.3 percent was met via the $295,000 grant from the state of California, 8.5 percent via patient fees and the sale of visual aids, 1.3 percent via a research grant from the federal Administration on Aging to study peer volunteers in service delivery, 1.3 percent via a grant from the city of Santa Monica, and 0.3 percent from interest on monies in banks and certificates of deposit.

9- Ratio of the number of dollars expended per new client served by the agency noted at left to the number of dollars expended per new patient served by CPS in the noted year. Example: ($1,428,000)(551)/(690,100)(82) = 13.90

4/86

Table 2

NATIONAL INFORMATION, REFERRAL, AND TRAINING CENTER FOR THE PARTIALLY SIGHTED

ESTIMATED COST OVER A FIVE-YEAR PERIOD

YEAR	1	2	3	4	5
Personnel	$213,166	$213,166	$203,515	$203,515	$203,515
Fringe Benefits[1]	68,213	68,213	65,125	65,125	65,125
Capital Equipment	25,000	25,000	20,000	20,000	15,000
Supplies					
Office	18,000	18,000	18,000	18,000	18,000
Computer	6,000	6,000	6,000	6,000	6,000
Travel					
National/Regional	13,500	13,500	13,500	13,500	13,500
Local	3,000	3,000	3,000	3,000	3,000
Other					
Center Produced Publications	45,000	45,000	45,000	45,000	45,000
Books & Periodicals	4,000	4,000	4,000	4,000	4,000
Equipment Maintenance	2,000	2,000	2,000	2,000	2,000
Postage	15,000	15,000	15,000	15,000	15,000
TOTAL DIRECT COST	**412,879**	**412,879**	**395,140**	**395,140**	**390,140**
INDIRECT COST[2]	174,546	174,546	168,813	168,813	168,813
TOTAL COST	587,425	587,425	563,953	563,953	558,953
TOTAL COST with 4% annual cost of living increase	587,425	610,922	609,972	634,370	653,896

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[1] 32 percent of salaries

[2] Indirect Cost = 45 percent of direct cost minus capital equipment

NATIONAL INFORMATION, REFERRAL, AND TRAINING CENTER FOR THE PARTIALLY SIGHTED

FIRST YEAR PERSONNEL COSTS

	Number of Days	Daily Rate	Total Remuneration
Task 1			
Data Specialist	114	$ 76.92	$ 8,769
Secretary	114	73.08	8,331
Task 2			
Computer Operator	114	80.00	9,120
Research Data Analyst	114	138.46	15,784
Research Analyst	114	64.00	7,296
Task 3			
Senior Clinical or Management Persons	114	176.92	20,169
Secretary	114	64.00	7,296
Task 4			
Development Specialist	57	184.62	10,523
Secretary	57	64.00	3,648
Task 5			
Senior Clinical or Research Persons	183	176.92	32,376
Secretary	114	64.00	7,296
Publications Specialist	57	111.54	6,358
Task 6			
Senior Clinical or Research Persons	69	176.92	12,207
Secretary	114	64.00	7,296
Publications Specialist	69	111.54	7,696
Social Service Persons	69	96.15	6,634
Optometrist	69	134.62	9,289
Task 7			
Senior Clinical or Research Persons	46	176.92	8,138
Senior Clinical or Management Persons	46	176.92	8,138
Social Service Persons	57	96.15	5,481
Secretary	57	64.00	3,648
Optometrist	57	134.62	7,673
TOTAL			$213,166

NATIONAL INFORMATION, TRAINING, AND REFERRAL CENTER FOR THE PARTIALLY SIGHTED

PERCENTAGE OF STAFF TIME OVER A PERIOD OF FIVE YEARS

YEAR	1	2	3	4	5
Task 1					
Data Specialist	50	50	40	40	40
Secretary	50	50	40	40	40
Task 2					
Computer Operator	50	50	50	50	50
Research Data Analyst	50	50	30	30	20
Research Analyst	50	50	50	50	50
Task 3					
Senior Clinical or Management Persons	50	50	50	50	50
Secretary	50	50	50	50	50
Task 4					
Development Specialist	25	25	25	25	25
Secretary	25	25	25	25	25
Task 5					
Senior Clinical or Research Persons	80	80	80	80	80
Secretary	50	50	50	50	50
Publications Specialist	25	25	25	25	25
Task 6					
Senior Clinical or Research Persons	30	30	30	30	30
Secretary	50	50	50	50	50
Publications Specialist	30	30	30	30	30
Social Service Persons	30	30	30	30	30
Optometrist	30	30	30	30	30
Task 7					
Senior Clinical or Research Persons	20	20	20	20	20
Senior Clinical or Management Persons	20	20	20	20	20
Social Service Persons	25	25	25	25	25
Secretary	25	25	25	25	25
Optometrist	25	25	25	25	25

Table 3

CPS

THE CENTER FOR THE PARTIALLY SIGHTED

919 Santa Monica Boulevard, Suite 200, Santa Monica, California 90401 (213) 458-3501

RESPONSES RECEIVED APRIL THROUGH DECEMBER 1984 TO
ARTICLE IN APRIL/MAY 1984 ISSUE OF MODERN MATURITY MAGAZINE*

State/Country	Total	State/Country	Total	State/Country	Total
Alabama	23	Maine	32	Pennsylvania	208
Alaska	4	Maryland	51	Rhode Island	14
Arizona	94	Massachusetts	61	So. Carolina	23
Arkansas	33	Michigan	100	So. Dakota	10
California	389	Minnesota	45	Tennessee	34
Colorado	42	Missouri	68	Texas	149
Connecticut	72	Mississippi	13	Utah	12
Delaware	9	Montana	14	Vermont	4
Dist. of Columbia	9	Nebraska	19	Virginia	60
Florida	366	Nevada	17	Washington	81
Georgia	40	New Hampshire	6	West Virginia	18
Hawaii	4	New Jersey	135	Wisconsin	65
Idaho	9	New Mexico	23	Wyoming	7
Illinois	217	New York	340	Puerto Rico	1
Indiana	45	No. Carolina	53	Switzerland	1
Iowa	39	No. Dakota	7	Israel	1
Kansas	31	Ohio	153	Nova Scotia	1
Kentucky	22	Oklahoma	29	Sub Total:	3,390
Louisiana	30	Oregon	57	Special Inquiries:	185
				Grand Total:	3,575

*Additionally, 185 inquiries required special attention, bringing the total to 3,575 for this period.

Appendix A

CPS

THE CENTER FOR THE PARTIALLY SIGHTED

919 Santa Monica Boulevard, Suite 200, Santa Monica, California 90401 (213) 458-3501

STAFF NETWORKING AND OUTREACH PRESENTATIONS
JULY 1985 - MARCH 1986

July

Montana Association for the Blind, Bozeman, Montana	Keynote address for annual meeting and networking with low vision care providers
Public Interest Radio and Television Educational Society	Networking and participation in meeting
Santa Monica/Westside Senior Task Force	Networking and participation in meeting

September

Santa Monica Health Fair, Santa Monica	Participation in health fair
Santa Monica/Westside Senior Task Force	Networking and participation in meeting
Planned Giving Roundtable	Seminar - networking

October

VTEK Open House	Networking with low vision care providers
Santa Monica Chamber of Commerce	Networking and participation in meeting
Group W Cable TV Workshop	Participation/networking with other nonprofit professionals
California Orientation and Mobility Specialists (CAOMS) Annual State Conference	Networking and participation in conference
Public-Interest Radio and Television Educational Society	Networking and participation in meeting
Santa Monica/Westside Senior Task Force	Networking and participation in meeting

November

Santa Monica College Emeritus College	Presentation to class

A California Nonprofit Public Benefit Corporation

November (continued)

National Gerontological Society, New Orleans, Louisiana	Presentation to annual meeting on CPS peer volunteer programs
Public Interest Radio and Television Educational Society	Networking and participation in meeting
Santa Monica Chamber of Commerce	Networking and participation in meeting
Internal Revenue Service, Los Angeles	Presentation to staff members
Planned Giving Roundtable	Seminar - networking
Sacramento	Informational visit with members of state legislature and members of administrative staffs
Santa Monica/Westside Senior Task Force	Networking and participation in meeting
Healthcare Public Relations and Marketing Association	Networking and participation in meeting
Center for Nonprofit Management Fund-raising Seminar	Networking, education, and participation in meeting
Scientific Advisory Board Meeting	Networking with members of Scientific Advisory Board
Santa Monica Chamber of Commerce	Networking and participation in meeting
Association for the Education and Rehabilitation of the Blind and Visually Impaired	Networking and participation in conference
Keith Geck, Digital Equipment Corporation	Inservice presentation
National Society of Fund-raising Executives	Seminar - networking
Pat Pincus/Ed Miska, Brentwood Square Savings	Inservice presentation
Art Ambrush, TRW	Inservice presentation

December

American Academy of Optometry, Atlanta Georgia	Networking with low vision specialists at annual meeting of organization
Santa Monica/Westside Senior Task Force	Networking and participation in meeting
Don Brooks, Arthur Young & Company	Inservice presentation
Los Angeles West Chamber of Commerce	Networking and participation in meeting

Staff Networking and Outreach Presentations
Page 3

January 1986

David Adomites, Video Editor	Inservice presentation
National Society of Fund-raising Executives	Networking and participation in meeting
Foundation for the Junior Blind	Outreach to foundation staff
Santa Monica Chamber of Commerce, Health Committee	Networking and participation in meeting
Public Interest Radio and Television Educational Society	Networking and participation in meeting
Healthcare Public Relations and Marketing Association	Networking and participation in meeting
Directors of Volunteers in Agencies (DOVIA)	Networking and participation in meeting
Planned Giving Round Table	Networking and participation in meeting

February

Asilomar Conference on Low Vision, Asilomar, California, American Foundation for the Blind	Networking, outreach, and participation in meeting
Thomas Walker, Chevron Corporation	Inservice presentation
Bruce Fane, Mitsui Manufacturers Bank	Inservice presentation
Jim Schooler, Santa Monica Bank	Inservice presentation
Angeles Girl Scout Council Conference, Carson, California	Outreach to conference participants
Los Angeles West Chamber of Commerce	Networking and participation in meeting
California Optometric Association Conference, Long Beach, California	Networking and participation in meeting
Ramona Gonzales, Bruce Berrol, Curtis Horton, Coro Foundation	Inservice presentation, preparation for making a CPS videotape for Coro Foundation awards banquet

March

Alan Katz, Member of Santa Monica City Council	Inservice presentation
Linda Cohen, Citicorp	Inservice presentation
Public Interest Radio and Television Educational Society	Outreach presentation to L.A. area radio/TV public service directors and representatives of nonprofit organizations
Jaimie Korody, Graphic Designer	Inservice presentation
National Society of Fund-raising Executives International Conference, Chicago	Networking and participation in meeting
Robin Kramer, Executive Director, Coro Foundation	Inservice presentation
CTEVH (California Transcribers and Educators of the Visually Handicapped) Conference, Los Angeles	Networking and participation in conference
American Foundation for the Blind Low Vision Task Force, New York City	Participation in task force on low vision quality care
California Department of Transportation Workshop, Los Angeles	Networking and participation in workshop
Robert Hayes, Senate Select Committee on Governmental Efficiency	Inservice presentation

Appendix B

THE CENTER FOR THE PARTIALLY SIGHTED
919 Santa Monica Boulevard, Suite 200, Santa Monica, California 90401 (213) 458-3501

TRAINING AND TECHNICAL ASSISTANCE
JULY 1985 - MARCH 1986

July 1985	
Psychology of Aging Class, UCLA	Lecture on vision changes with age
Ventura College Class	Inservice presentation
Arizona Low Vision Service	Inservice and technical assistance
Los Angeles area counselor/teachers, California Department of Rehabilitation	Presentation and technical assistance for counselor/teachers
August	
Martha Pamperin, Sacramento	Inservice/introduction to CPS services
Jules Stein Eye Institute	Inservice/technical assistance for ophthalmological residents
Chris Vrischo, West Germany	Inservice and technical assistance
Ian Bruce, Royal Institute for the Blind, England	Inservice/introduction to CPS services
September	
Howard Krauss, M.D., Santa Monica	Inservice/introduction to CPS services
Marion Yoshida, Charlotte Kuhn, Blind Childrens Center	Inservice/introduction to CPS services
Yasuo Minegishi, Kiryu Eye Clinic, Japan	Inservice/introduction to CPS services
Sam Otsuji, O.D., Gardena	Inservice/introduction to CPS services
Lisa Massey and Bob McCaman, Office of Assemblyman Gerald Felando	Inservice/introduction to CPS services
Southern California College of Optometry, Fullerton	Lecture to optometric technicians
M. Bickert, Office of P. Hartman, M.D., Lakewood	Inservice/introduction to CPS services

A California Nonprofit Public Benefit Corporation

October

Jean Katzman, Speech and Hearing Therapist, Santa Monica	Technical assistance relative to patients with vision loss as well as hearing problems
Paul Freeman, O.D., Pennsylvania	Inservice/introduction to CPS services for low vision specialist
Dave Recupero, Leisure World Medical Clinic	Inservice/technical assistance regarding possible low vision services at Leisure World
Will Wallace, Los Angeles, member of staff of former state senator Alan Sieroty	Inservice/introduction to CPS services
National Organisation for the Blind, Madrid, Spain	Inservice presentation/technical assistance for five staff members of organization initiating low vision care
Olga Overbury, Western Blind Rehabilitation Center, Palo Alto, and Low Vision Center, Royal Victoria Hospital, Montreal, Canada	Three-day technical assistance/training at CPS

November

Audrey Hebner, Sacramento Society for the Blind	Inservice/introduction to CPS services
Linda Taber-Beck, San Francisco City Schools	Inservice/introduction to CPS services for orientation & mobility instructor
Marvin Brotman, Charlene Brotman, Brotman Communications, Boston, Massachusetts	Inservice/technical assistance for low vision communications consultants
Southern California College of Optometry Fullerton	Lecture to senior optometric students on communication skills with older adults

December

Sharon Cromeenes, Montana Low Vision Clinic, Helena, Montana	Technical assistance for low vision clinic coordinator
Kamak Lal, India	Inservice/technical assistance for teacher interning at Perkins School for the Blind, Watertown, Massachusetts

January 1986

Bill Cannon, Foundation for the Junior Blind	Inservice/introduction to CPS services
Pat Azarnoff, Pediatric Projects	Inservice/introduction to CPS services
K. J. Marshall, Director, Ebenezer School for the Blind, Hong Kong	Inservice/introduction to CPS services

February

Asilomar Conference on Low Vision, American Foundation for the Blind, Asilomar, California	Presentations and technical assistance to conference participants
"Some Comments on Low Vision Aids for Partially Sighted Older Workers," prepared for Conference on Work, Aging and Vision, Working Group on Aging Workers and Visual Impairment, National Research Council Committee on Aging Workers and Visual Impairment	Working paper for conference participants
Jessica Lampert, O & M student, California State University, Los Angeles	Inservice and technical assistance
Class from California State University, Los Angeles, for O & M instructors and teachers of the visually impaired	Inservice presentation and technical training for 20 students
Margaret Lawrence, Administrator, Low Vision Clinic, Melbourne, Australia	Inservice/introduction to CPS services
Helen Robbins, O.D., low vision specialist, Melbourne, Australia	Inservice/introduction to CPS services
Gardena Valley Affiliated Committee on Aging Workshop, "When You Can't Do It Yourself," Gardena Community Center	Participation in workshop
Dwayne Mitzel, M.D., Phoenix, Arizona	Inservice/introduction to CPS services

March

"Low Vision Care in a Clinical Setting," Chapter in book, Vision and Aging, General and Clinical Perspectives	Book for professionals working with older people and visually impaired people
Jack Christ, O.D., low vision specialist, Blackfoot, Idaho	Inservice/introduction to CPS services
Robert Ralls, Judy Lloyd, Chaulmaine Fuller, Foundation for the Junior Blind	Inservice/introduction to CPS services
Yolanda Compara, Foundation for the Junior Blind	Inservice/introduction to CPS services
Darrell McDaniel Independent Living Center, Van Nuys, California	Outreach/technical assistance
St. Augustine's Church, Santa Monica	Training and technical assistance to make church safer and more accessible to partially sighted people

STATEMENT OF DAVID C. DANIELS, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
TO THE SUBCOMMITTEE ON LABOR, HEALTH,
HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

The American Legion appreciates the opportunity to express its views on the bilingual education portion of the Department of Education's Fiscal Year 1987 budget.

The Department of Education proposes to maintain the bilingual education program at the 1986 presequester level of $143 million. The American Legion strongly believes in the federal role in assisting local school districts attempting to educate an increasingly divergent group of students. The level of funds requested by the Administration are probably adequate if certain other changes are concurrently implemented in the bilingual education program.

With passage of the Bilingual Education Act in 1968, the federal government began to play a role in assisting local school districts in teaching English to students whose primary language was not English. In subsequent reauthorizations the emphasis of bilingual education program began to shift from a focus on acquisition of proficiency in the English language to a policy instead stressing pride in one's cultural heritage. While cultural heritage and diversity of backgrounds have always been an important part of American culture due to the immigrant makeup of this country, the focus must never be shifted from the absolute necessity of obtaining proficiency in English. It is a tragic fact that citizens who are unable to skillfully communicate in English become victims of an unrealistic policy. Being denied their full rights and responsibilities as U.S. citizens due to their lack of ability to participate fully in the political and economic benefits of an increasingly competitive American society, citizens with English language deficiencies are sadly precluded from reaching their full potential.

Since the mid to late 1970's the primary instructional technique for teaching English relied on using the child's native language as the medium of instruction until such time a child could function successfully in classrooms taught in English. Much controversy continues to surround the mixed results of this technique known as "transitional bilingual education."

Mr. Chairman, The American Legion is not qualified to make a judgement as to what teaching technique, if any, is superior to another. We do know that many school districts through-out this land have enjoyed success with various alternative instructional methods. We believe that a great need exists for local communities to have the flexibility to choose whatever teaching technique that is likely to achieve success for their limited English proficient children.

Currently, Congress has effectively mandated a single teaching method by requiring that 96% of pertinent bilingual education funds be expended on teaching the transitional bilingual education method. Many local school districts having multi-national children representing as many as 70 different languages have found it impossible to find skilled teachers to teach children in their own languages as mandated by Congress and have been precluded from participation in the bilingual education program. Last year up to 25 percent of applications for bilingual education assistance requested funds for alternative instruction methods in which only 4% of funds were available.

The American Legion fully supports the bipartisan initiative that Secretary of Education William Bennett has launched to increase the level of flexibility allowed in teaching alternative methods stressing a proficiency in English as quickly as possible. We urge all members of the House and Senate to support legislative initiatives currently pending in both chambers which have been designed to return to the local school districts the ability to choose the method of instruction which best suits the needs of their own unique circumstances.

Testimony of the Navajo Nation
on the
Appropriation for
Indian Vocational Rehabilitation

April 30, 1986

These comments are presented for inclusion in the record of the hearings on the appropriations for FY 1987 for rehabilitation services through the U.S. Department of Education. The comments particularly concern that part of the appropriation dealing with funding for tribally operated vocational rehabilitation programs. The Navajo Nation is interested in this part of the appropriation for rehabilitation services because of its impact on the Navajo Vocational Rehabilitation Program. In addition, we are concerned with the impact of the proposed funding level on the quality and availability of vocational rehabilitation services for American Indians throughout the country.

The situation of handicapped American Indians across the United States reflects a number of differences from the rest of the handicapped population. A report prepared by the Native American Research and Training Center at Northern Arizona University indicates that the overall incidence of disabling conditions among American Indians is one and a half times higher than among the rest of the American population. Despite this higher incidence of handicapping conditions, disabled American Indians are only 60% as likely as disabled members of the general population to be successfully rehabilitated. American Indians are less likely to apply for rehabilitation services. If they apply, they are less likely to be accepted. If accepted into the caseload, they are less likely to be rehabilitated. More specific data from the Research and Training Center report are appended to this testimony as Exhibit A.

Factors which contribute to the lower rehabilitation rate for American Indians include the geographical isolation of many American Indian vocational rehabilitation clients. VR services tend to be clustered in the more settled, urban areas. Indian reservations are usually found in isolated, rural areas. There is often a gulf of language and culture between the American Indian VR client and the rehabilitation services providers in the surrounding non-Indian society. Based on the experience of the Navajo Vocational Rehabilitation Program, we believe that these barriers of geography, language and culture can best be overcome by providing vocational rehabilitation services through the tribe itself.

The Navajo Vocational Rehabilitation Program (NRVP) has been providing a tribally-based alternative to conventional rehabilitation services for the Navajo handicapped population since 1975. It operates like a state VR program. The program maintains a caseload of over 450 active clients. The states of Arizona, New Mexico and Utah have not been able to effectively serve this population and look to the Navajo program to be the primary service provider in this area. Nonetheless, in the years since 1981 when Congress first appropriated funds the Special Projects line item for Indian Vocational Rehabilitation, NVRP has continued to be treated as a discretionary program. This has meant that NVRP has had to apply each year for its funding with no real assurance that the funding application would be accepted. It has also meant that the U.S. Department of Education has felt no obligation to seek funding for Indian vocational rehabilitation at a program maintenance level or to give any priority to NVRP, as an established program, in the allocation of available funds.

In each budget cycle since 1981, the Navajo Nation has had to fight for NVRP's funding. In FY 1985, when a number of other tribes submitted applications for Indian VR funds, we sought successfully to have the funds available for Indian vocational rehabilitation increased from $715.000 to $1,430,000. This increase was necessary to fund any additional Tribal programs without gutting the Navajo program. We felt it was a reasonable increase in light of the Department's reported receipt of Tribal applications requesting over $2 million. Despite the fact that Congress did authorize the supplemental appropriation for Indian vocational rehabilitation and that other tribes did apply for the funding, the Department returned $300,000 of the 1985 funds to the treasury and sought to return to a funding level of $715,000 for fiscal year 1986. This amount was not even sufficient to maintain the funding for the programs to which the Department did award grants.

The appropriation for FY 1986 was established at the full 1985 level of $1,430,000. Nonetheless, the Department of Education once again returns to Congress seeking only $715,000 for the Indian vocational rehabilitation program in FY 1987. Once again, this amount is not even sufficient to maintain the funding level for existing programs.

We are asking this subcommittee to assure that adequate funding is appropriated for Indian vocational rehabilitation in the FY 1987 budget. Authorizing legislation is now before Congress which, if adopted in its present form, would assure funding for Indian vocational rehabilitation programs under Section 130 at no less than .25% of the amount appropriated for state VR programs. We hope that this legislation will be adopted and that it will result in a stabilizing of the funding of Indian VR programs.

The fate of the reauthorization bill is not certain, however. Nor do we dare rely upon the proposed .25% funding floor. For that reason, we urge this committee to assure that the funding level for Indian vocational rehabilitation programs is maintained at no less than $1,430.000. If the reauthorization bill as adopted, does contain an assurance of funding at no less than .25% of the appropriation for state basic grants, this amount, of course would replace the Special Projects appropriation. However, if the reauthorization bill does not contain such a change, it will be essential to assure that Indian VR programs continue to have funding available at the FY 1986 level so that they can continue to meet their service obligations to handicapped tribal members.

We are concerned about avoiding any precipitous drop in funding which could endanger the maintenance of services to our clients or to the clients of any other tribal program. We want to avoid program funding cuts that could result in the loss of experienced Navajo rehabilitation counsellors. Therefore, we urge this subcommittee to protect the existing funding level for Indian vocational rehabilitation and to include an appropriation of at least the FY 1986 level in the proposed appropriation bill for rehabilitation services for FY 1987.

EXHIBIT A

Excerpt from the Testimony
of the Navajo Nation to the
Subcommittee on Select Education
Submitted July 27, 1985

HANDICAPPED NATIVE AMERICANS AND REHABILITATION

The situation of handicapped Native Americans throughout the country reflects a number of differences form the rest of the handicapped population. The incidence of many handicapping conditions is greater among Native Americans. The relative distribution of different handicapping conditions is different from the general population. The access to rehabilitation services of handicapped Native Americans is less than the general population. Their rate of acceptance by rehabilitation services is lower, as is the rate of rehabilitation for those accepted for services. *

Within the categories of handicapping conditions among persons accepted for vocational rehabilitation caseloads, Native Americans have reported higher incidents of disability than the general population in regard to accidental injury of the eye (1.28 times the general population), injuries to the spinal cord (1.13), infections of the ear (1.03), arthritis (1.17), accidental loss of limb (1.11), dental conditions (1.61) and end stage renal failure (1.98). These figures actually underestimate the amount of trauma-caused disability, since accidents are the leading case of death and traumatic hospitalization among Native Americans.

Leading the causes of disability, and highly implicated in many of the other disabilities reported for Native Americans is alcoholism (3.21 times the average for the general population). "Other character disorders" are also reported at higher than the national average (1.16). Native American rehabilitation clients are more likely than the handicapped general population to have a secondary disability. This disability is most likely to be classified as alcoholism.

In those disabilities which appear with greater frequency among Native Americans, the rate of rehabilitation is often less than the rate for the general population. For example, 61.7% of the cases of accidental eye injury accepted for rehabilitation services from the general population are successfully rehabilitated. Only 53% of the Native Americans with this disability accepted for services are rehabilitated. 73% of those from the general population accepted for services with accidental loss of limb are successfully rehabilitated. For Native Americans with this condition, the

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* The Navajo Nation expresses its appreciation to the Native American Research and Training Center at Northern Arizona University for making its information on the incidence of handicapping conditions and rehabilitation of Native American handicapped available to the Navajo Nation for this document. Conclusions drawn from that data are those of the Navajo Nation.

rate of rehabilitation for those accepted for services is only 58.3%. Persons accepted from the general population for rehabilitation services because of alcoholism show a rehabilitation rate of 52.6%. For Native Americans, the rehabilitation rate is 37%.

One of the most common reasons given in rehabilitation services reports for the failure to accept Native Americans into the rehabilitation caseload or for the failure to successfully rehabilitate is the inability to locate the client after the initial contact. A report of the Rehabilitation Services Administration for cases closed in 1978 indicates that 25% of the Native American cases were closed out because of the failure to locate the client, compared to 15% for the general population. This figure reflects, among other things, the geographic isolation of the Native American VR client and the concentration of VR services in the most settled, urban areas. It also reflects the gulf of language and culture between the disabled Native American and the rehabilitation service providers in the dominant society.

What those figures and reports demonstrate is that the Native American population has a greater need for rehabilitation services than does the general population. Yet, those services are less available to Native Americans, particularly those living on reservation, than to the general population. A recent article published in American Rehabilitation (Jan/Feb/Mar 1985), concluded:

> "Evidence indicates that (Federally funded health care agencies) -- i.e. Rehabilitation Services Administration, Special Education, Administration on Aging -- have neither served the Indian handicapped and disabled on a scale commensurate to their needs, nor formally approached tribal entities to resolve jurisdictional, culture, linguistic and other barriers that impede service delivery." ("Handicapping and Disabling Conditions in Native American Populations," by Jamil. L. Toubbeh)

The Rehabilitation Services Administration in its report on the RSA-300 data for fiscal year 1978 also concluded:

> "The Indian population on reservations, including the disabled population, are not conveniently located for easy participation in general Federal and State programs; ... If there is any single, important step that RSA should consider in order to improve VR services to Native Americans, that step is developing ways to take VR to the reservation Indians. It is not likely that they will or even can come to VR in highly significant numbers.

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RP Foundation Fighting Blindness

HOUSE COMMITTEE ON APPROPRIATIONS

April 23, 1986

Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Mr. Chairman and Members of the Committee:

We of the National Retinitis Pigmentosa Foundation are in complete support of the 1987 Citizens Budget Request of $245,000,000 for the National Eye Institute of the National Institutes of Health. This Citizens Budget would allow each research program activity, through which vision research is pursued, to continue in 1987 with strength and stability. In contrast, the 1987 President's Budget Request for the National Eye Institute is lower than the estimated 1986 budget and would result in lost momentum and constricted efforts in vision research.

The momentum generated by recent exciting research in the field of eye disease is too valuable to be sacrificed by an inadequate budget. The National Retinitis Pigmentosa Foundation (NRPF) represents 400,000 Americans who suffer severe loss of vision, even blindness, from retinal degeneration. Retinitis pigmentosa, macular degeneration and Usher's syndrome are the most frequent forms of blinding retinal degeneration. At this time there is no prevention, treatment or cure. People

There is an answer if only you'll help us find it
Member of NHA/Combined Federal Campaign; International RP Association

affected by these diseases depend upon our nation's research programs to give them hope that the causes of blindness will eventually be understood. They anticipate and scrutinize each step researchers make toward finding the cure to the eye disease from which they, and possibly their families, suffer greatly.

In the belief that medical research will always be a top national priority, this large group of vision impaired people are making their own unique and precious contributions: their eyes, their histories, and their blood. Under three programs designed, supported and vigorously administered by the NRPF,their contributions are made available to researchers. But these contributions would be underutilized or even lost if sufficient research funds were not available for the relevant studies.

One of these programs, the National Retina Donor Program, was initiated by NRPF in 1980 to meet the acute, increasing need of researchers to study retinal tissue from deceased persons affected by retinal degenerations or from members of their families. A very reliable retina donor notification and retrieval system has been developed so that eyes can be prepared and shipped to researchers as soon as possible after death to maximize the specimen's usefulness in biochemical research. These invaluable anatomical gifts have greatly enhanced research efforts.

A computerized registry program of family histories has been developed by the NRPF and is constantly being updated in an effort to register all persons with an inherited retinal degenerative disease. From this registry, researchers are able to identify and contact the members regarding participation in relevant research programs and clinical treatment trials. Since large numbers of volunteers are needed for most studies, the registry is a valuable resource for investigators. It should not go unused due to insufficient research funds.

Three multi-generational families totaling 350 members, with inherited retinal degeneration, have volunteered to donate blood samples for a program sponsored by the NRPF. Under this program, blood cell cultures will be established and banked to provide to researchers an unlimited biological resource for studies on the genetics of retinal degeneration. DNA can be isolated from the cultured cells and used to identify and characterize, through recombinant DNA approaches, the various genes causing retinal degeneration. Although such investigations are expensive, they provide insights into disease at the most basic, molecular level. These cell cultures will be used only if research funding is available for such studies.

Recent research break-throughs and the current development of research resources constitute the momentum upon which new findings are built. If this momentum is interrupted due to inadequate funding of research by the National Eye Institute, our future progress will be seriously jeopardized.

We urge that you give your full and enthusiastic support to the 1987 Citizens Budget for the National Eye Institute so that important programs, exemplified by those described above, can be used for vision research. The hope of the vision impaired lies in this research, to which they eagerly and willingly make their own special contributions. We also urge that you support provision of funds for instrumentation and construction at the level of $10 million as requested in the Citizens Budget. Even though adequate equipment and facilities are a basic requirement for conducting research, the President's budget request has completely neglected this need.

TESTIMONY OF THE NATIONAL ASSOCIATION OF STATE EMERGENCY MEDICAL SERVICES DIRECTORS

TO THE

SUBCOMMITTEE ON LABOR, HEALTH, EDUCATION AND WELFARE

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

APRIL 23, 1986

Mr. Chairman and members of the Subcommittee, my name is Susan D. McHenry and I am here today representing the National Association of State Emergency Medical Services Directors. My other role is that of Director of the Division of Emergency Medical Services in Virginia.

The National Association of State Emergency Medical Services Directors is composed of the director of the lead emergency medical services agency in each state, the District of Columbia, and the U.S. territories. Each of these agencies has the responsibility for the development of emergency medical services in their respective state or territory, as well as for licensing and inspecting ambulances, certifying emergency medical services personnel, and other activities related to maintaining minimum standards for prehospital emergency care.

As an Association, one of our purposes is to ensure continued support for the ongoing development of emergency medical services by working with the federal government. It is in this vein that I want to take the opportunity to present our views on the appropriations for the Preventive Health and Health Services Block Grant Program of the Department of Health and Human Services, now being considered by your Subcommittee.

Our Association has a very strong commitment to the continuation of comprehensive EMS system programs in the United States in order to prevent death and disability, thousands of times daily, throughout the nation. The early 1970's saw the passage of the Emergency Medical Services Act which heralded a major national effort to improve emergency medical services in this country. This program, administered by the Department of Health and Human Services, supplemented the ongoing work of the Department of Transportation. The changes stemming from this national movement are evident to some degree in virtually every communmity across this country.

With the replacement of this categorical grant program by the Preventive Health and Health Services Block Grant Program in 1981, the Emergency Medical Services Program suffered a substantial reduction in federal support, both in terms of funding and program leadership. In FY 86, less than $15 million, approximately 16 percent of the total Preventive Health and Health Services Block Grant, was allocated to emergency medical services. Ten states received no money for EMS from this Block Grant and in many states the level of support is progressively dwindling.

We would urge continued funding of the Preventive Health and Health Services Block Grant at at least its current level, but would further urge that adequate funding be provided for both the preventive and the health services aspects that must be addressed to effectively serve the citizens of this nation.

The National Association of State Emergency Medical Services Directors also believes that the flexibility of the block grant programs must be maintained in order to permit states to use this funding in relation to the emergency medical services needs and priorities that exist in each state now and in the future.

The Subcommittee on Labor, Health, Education, and Welfare is urged to act favorably to continue the Preventive Health and Health Service Block Grant Program and to ensure that adequate funding is provided in order that emergency medical services systems throughout the nation are kept viable to be able to further reduce death and disability resulting from sudden illness and serious injury.

Respectively Submitted,

Susan D. McHenry
Past President
National Association of
State EMS Directors
P. O. Box 11910
Lexington, KY 40678

National Association of State Emergency Medical Services Directors
Preventive Health & Health Services Block Grant Funding
FY 86

State	Total Prev. Health Block Grant Allocation	Prev. Health Block Grant Monies Allocated to EMS	Percent of Total
Alabama	$ 1,504,730	$ 257,000	17.1
Alaska	326,890	50,000	15.3
Arizona	1,089,835	100,000	9.2
Arkansas	844,454	30,000	3.5
California	6,320,373	1,800,000	28.5
Colorado	1,153,056	100,000	7.2
Connecticut	1,379,453	170,000	12.3
Delaware	173,300	-0-	0
Dist.of Columbia	743,890	18,000	2.4
Florida	2,722,585	-0-	0
Georgia	2,894,030	100,000	3.4
Hawaii	743,827	210,000	28.2
Idaho	346,443	42,000	12.1
Illinois	2,209,214	-0-	0
Indiana	1,586,101	250,000	15.7
Iowa	1,047,495	240,000	22.9
Kansas	890,353	-0-	0
Kentucky	1,270,572	-0-	0
Louisiana	2,779,436	848,000	30.5
Maine	853,644	398,886	46.7
Maryland	1,777,482	196,000	11.0
Massachusetts	2,582,426	1,040,000	40.2
Michigan	3,757,928	177,000	4.7
Minnesota	2,403,615	602,000	2.5
Mississippi	1,385,659	249,000	17.9
Missouri	2,368,008	480,000	20.2
Montana	632,187	185,439	29.3
Nebraska	1,594,861	350,000	21.9
Nevada	348,687	41,000	11.7
New Hampshire	1,365,676	700,000	51.1
New Jersey	2,735,859	300,000	10.9
New Mexico	1,336,564	730,000	54.6
New York	6,540,843	1,080,000	16.5
North Carolina	2,574,170	250,000	9.7
North Dakota	243,687	-0-	0
Ohio	4,311,614	52,000	1.2
Oklahoma	884,352	280,000	31.6
Oregon	669,502	54,329	8.1
Pennsylvania	4,543,342	905,000	19.9
Puerto Rico	1,484,615		
Rhode Island	451,828	-0-	0
South Carolina	1,154,336	190,000	16.4
South Dakota	220,231	-0-	0
Tennessee	1,525,908	55,000	3.6
Texas	3,731,712	700,000	18.7
Utah	905,016	151,900	15.8
Vermont	259,151	-0-	0
Virginia	1,907,873	100,000	5.2
Virgin Islands	166,727		
Washington	921,769	-0-	0
West Virginia	859,607	593,000	68.9
Wisconsin	1,854,342	100,000	5.4
Wyoming	216,550	110,000	50.8
Totals	$88,595,808	$14,285,554	16.0

THE ASSOCIATION FOR RESEARCH IN VISION AND OPHTHALMOLOGY, INC.

Statement from the Association for Research in Vision and Ophthalmology before the U.S. House Subcommittee on Appropriations for Labor, Health and Human Services and Education in Support of the Proposal 1987 Citizens Budget for the National Eye Institute.

The Association for Research in Vision and Ophthalmology (ARVO) strongly supports the proposed 1987 Citizens Budget of $245,000,000 for the National Eye Institute (NEI) of the National Institutes of Health (NIH).

Founded in 1928 to encourage and assist research, training, publication and dissemination of knowledge in vision and ophthalmology, ARVO has over 4,000 members representing every region in the United States. The majority of its membership conducts serious vision and ophthalmology research supported by NEI. This research has resulted in dramatic improvements in the treatment of more than eleven million Americans suffering from permanent visual disabilities. Examples of recent significant accomplishments due to funding sponsored by NEI include:

- The development of a focal treatment with a laser that can halt or even reverse the visual loss that occurs in many people with diabetic macular edema.

- The location of the gene believed responsible for retinitis pigmentosa, a blinding hereditary disease that strikes children and adolescents. This information may ultimately lead to the development of gene therapy for this disease.

- A decade of basic research on the formation of diabetic cataracts through the action of aldose reductase has not only paved the way for the development of drugs such as sorbinil, that inhibit the enzyme, but has also opened other avenues of investigation into the role of aldose reductase in a variety of diabetic complications. Ongoing work should lead to a more precise understanding and control of the pathological effects observed in diabetes and be useful in designing anti-cataract drugs.

The proposed 1987 Citizens Budget for NEI also recognizes the ongoing need for support in the training of vision and ophthalmology researchers. The current advancements in the diagnosis and treatment of eye diseases must be continued. In addition, the budget includes funding for the modernization of research facilities. This is particularly critical in light of the newly revised Public Health Service Animal Welfare Policy, which places more stringent regulations on the care of laboratory animals.

The ARVO membership believes the proposed $245,000,000 for NEI is both necessary and justified, if the level and quality of eye research is to continue in this country. We urge the committee members to review the significant accomplishments of the NEI and consider the porposed 1987 Citizens' Budget as essential to the treatment of the visually impaired citizens of this country.

JOINT TESTIMONY
TO THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

ON

FISCAL YEAR 1987 APPROPRIATIONS FOR THE DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS) AND THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)

April 9, 1986

Submitted By

NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC.
P. O. Box 1417-D49
Alexandria, Virginia 22313

NATIONAL ASSOCIATION OF RETAIL DRUGGISTS
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AMERICAN PHARMACEUTICAL ASSOCIATION
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INTRODUCTION

THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC., (NACDS), THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS, (NARD), AND THE AMERICAN PHARMACEUTICAL ASSOCIATION, (APHA) RESPECTFULLY SUBMIT THE FOLLOWING WRITTEN TESTIMONY FOR THE RECORD RELATIVE TO THE FISCAL YEAR 1987 APPROPRIATIONS BILL FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) AND THE HEALTH CARE FINANCING ADMINISTRATION (HCFA).

NACDS IS A NON-PROFIT TRADE ASSOCIATION FOUNDED IN 1933 WHICH REPRESENTS THE MANAGEMENT OF MORE THAN 171 CHAIN DRUG CORPORATIONS. IN TOTAL, NACDS CORPORATE MEMBERS ARE CURRENTLY OPERATING IN EXCESS OF 18,000 RETAIL DRUG STORES THROUGHOUT THE UNITED STATES. FOUNDED IN 1898, NARD REPRESENTS THE OWNERS OF MORE THAN 30,000 INDEPENDENT PHARMACIES WHERE 75,000 PHARMACISTS PRACTICE THEIR PROFESSION. THE PHARMACISTS DISPENSE APPROXIMATELY 70 PERCENT OF ALL PRESCRIPTIONS AND SERVE 18 MILLION CONSUMERS DAILY. OVER 60 PERCENT OF NARD'S MEMBERS PROVIDE HOME HEALTH CARE PHARMACY SERVICES. APHA IS THE NATIONAL PROFESSIONAL SOCIETY OF PHARMACISTS REPRESENTING THE THIRD LARGEST HEALTH PROFESSION COMPRISED OF PHARMACY PRACTITIONERS, PHARMACEUTICAL SCIENTISTS AND PHARMACY STUDENTS. SINCE ITS FOUNDING IN 1852, APHA HAS BEEN A LEADER IN THE PROFESSIONAL AND SCIENTIFIC ADVANCEMENT OF PHARMACY AND SAFEGUARDING THE WELL-BEING OF THE INDIVIDUAL PATIENT.

THE PURPOSE OF OUR JOINT TESTIMONY TO THE SUBCOMMITTEE IS TO

PRESENT ONE KEY RECOMMENDATION THAT WE SINCERELY BELIEVE WILL MAKE THE MEDICAID PROGRAM MORE EFFICIENT AND EQUITABLE. IT IS OUR FIRM BELIEF THAT IF THIS IMPORTANT FEDERAL HEALTH CARE PROGRAM WERE TO TAKE ADVANTAGE OF THE STRENGTHS OF THE FREE MARKETPLACE AND THE COMPETITIVE ENVIRONMENT IN WHICH RETAIL DRUG STORES OPERATE IN THE CONTEXT OF OUR RECOMMENDATION, THERE WOULD BE LONG-TERM SAVINGS FOR THE FEDERAL GOVERNMENT AND STATES. ESSENTIALLY, WE ARE ADVOCATING A MORE INNOVATIVE APPROACH TO THE FUNDAMENTAL MECHANICS OF ADMINISTRATION AND THE PROVIDING OF PRESCRIPTION DRUGS TO NEEDY RECIPIENTS.

ISSUE - APPLICABILITY OF DRUG VOUCHERS FOR MEDICAID

IN THIS REGARD, WE BELIEVE THAT THE APPLICATION OF DRUG VOUCHERS TO THE MEDICAID PROGRAM WARRANTS CAREFUL CONSIDERATION AND ATTENTION BY THE CONGRESS: COLLECTIVELY, OUR ASSOCIATIONS ARE OF THE OPINION THAT SUCH A SYSTEM WOULD ACHIEVE SUBSTANTIAL COST SAVINGS, BECAUSE VOUCHERS WOULD PROMOTE EASE OF ADMINISTRATION AND A CORRESPONDING REDUCTION IN PAPERWORK. SINCE HCFA DATA SHOWS THAT MORE THAN 50 PERCENT OF ALL MEDICAID PAPERWORK IS TRIGGERED BY DRUG CLAIMS WHICH CONSTITUTE ONLY SIX TO EIGHT PERCENT OF THE TOTAL PROGRAM EXPENDITURES, A WELL-FASHIONED DRUG VOUCHER PROGRAM WOULD GREATLY REDUCE THE HIGH ADMINISTRATIVE COSTS THAT ARE INHERENT IN THE WAY IN WHICH DRUG CLAIMS ARE CURRENTLY PROCESSED. WE HAVE SEEN ESTIMATES THAT VOUCHERS REDUCE ADMINISTRATIVE COSTS BY AS MUCH AS 66 PERCENT PER SUBMITTED DRUG CLAIM.

THERE ARE A NUMBER OF WAYS IN WHICH TO DESIGN A VIABLE DRUG VOUCHER OR CERTIFICATE PROGRAM. ONE WAY WOULD BE TO MODEL VOUCHERS AFTER BANK DRAFTS IN WHICH RECIPIENTS RECEIVE NUMBERED CERTIFICATES SIMILAR TO A CHECKING ACCOUNT. UNDER THIS APPROACH, VOUCHERS WOULD HAVE SPACE FOR NECESSARY INFORMATION SUCH AS PATIENT, PROVIDER AND PHARMACIST IDENTIFICATION, DRUG CODING, AND QUANTITY AND REFILL STATUS. RECIPIENTS COULD BE GIVEN DRUG VOUCHERS REPRESENTING A CERTAIN DOLLAR AMOUNT WHICH WOULD BE UTILIZED FOR THE PRUDENT PURCHASES OF NEEDED MEDICATIONS OR THE CERTIFICATES COULD SIMPLY REPRESENT ONE PRESCRIPTION THAT UPON PRESENTATION OF THE VOUCHER THE MEDICATION IS DISPENSED TO THE RECIPIENT BY THE PHARMACIST.

SUCH A VOUCHER SYSTEM WORKED EXTREMELY WELL IN ALABAMA FOR SOME SEVEN YEARS AND RECEIVED A CITATION OF EXCELLENCE FROM THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (HEW) SIGNED BY REGION IV COMMISSIONER VIRGINIA SMYTH. A COPY OF THE CITATION IS ATTACHED WITH OUR STATEMENT. THE ALABAMA VOUCHER PROGRAM CERTAINLY ASSURED PROMPT PAYMENT AND DID NOT AFFECT THE LEVEL OR METHODOLOGY OF PAYMENT TO PROVIDERS. THE DELAWARE BLUE CROSS/BLUE SHIELD PROGRAM HAS ALSO INITIATED A PRESCRIPTION DRUG VOUCHER DRAFT PROGRAM THAT HAS BEEN HIGHLY SUCCESSFUL.

SMART CARDS FOR THE MEDICAID PROGRAM

ANOTHER APPROACH TO THE DRUG VOUCHER CONCEPT WOULD BE TO FASHION

THE PROGRAM AFTER THE LATEST ADVANCED TECHNOLOGY UTILIZING THE SO-CALLED "SMART CARD." IN OUR OPINION, IF MEDICAID WERE TO ADOPT THE "SMART CARD" VIRTUALLY ALL FRAUD, WASTE AND ABUSE WOULD BE ELIMINATED. SMART CARDS WOULD RESEMBLE CONVENTIONAL CREDIT OR ELECTRONIC BANKING CARDS. UNDER THIS TYPE OF A SYSTEM, THE RECIPIENT'S CARD WOULD BE PROGRAMMED WITH ALL NECESSARY INFORMATION INCLUDING A MEDICAL PROFILE WHICH WOULD ENHANCE PATIENT CARE BY ASSISTING THE PHARMACIST IN CHECKING FOR POTENTIAL MEDICATION PROBLEMS SUCH AS ADVERSE REACTIONS AND SIDE EFFECTS.

OTHER IMPORTANT ASPECTS OF THE "SMART CARD" INCLUDE INSTANTANEOUS VERIFICATION OF ELIGIBILITY, EXPEDITED PAYMENT TO THE RETAIL DRUG STORE AND IMPROVED SECURITY IN THE EVENT THAT THE CARD IS STOLEN OR LOST. ADDITIONALLY, UNDER A SMART CARD SYSTEM, NOT ONLY IS THE ADMINISTRATIVE BURDEN SIGNIFICANTLY REDUCED FOR THE STATE MEDICAID PROGRAM, BUT THE SAME PAPERWORK BURDEN IS CORRESPONDINGLY REDUCED FOR THE PHARMACIST SO THAT MORE TIME CAN BE SPENT CONSULTING WITH THE PATIENT. FINALLY, WE SHOULD MENTION THAT SMART CARDS WOULD BE VERY COMPATIBLE WITH THE MMIS SYSTEM THAT MANY STATE MEDICAID AGENCIES HAVE IN PLACE.

THE SUBCOMMITTEE SHOULD BE FURTHER ADVISED THAT THERE ARE MANY AGENCIES WITHIN THE FEDERAL GOVERNMENT THAT ARE MOVING FORWARD IN TESTING AND ADOPTING SMART CARDS FOR VARIOUS PROGRAMS. THE U. S. DEPARTMENT OF AGRICULTURE IS CURRENTLY EXPERIMENTING WITH SMART CARDS AS AN ALTERNATIVE METHOD FOR DELIVERING FOOD STAMP

BENEFITS IN PENNSYLVANIA. THIS DEMONSTRATION PROGRAM, STARTED IN 1983, HAS PROVEN SO SUCCESSFUL THAT THE PROJECT WAS EXTENDED FOR AN ADDITIONAL 15 MONTHS, AND IT IS OUR UNDERSTANDING THAT AS OF MARCH 31, 1986, THE STATE OF PENNSYLVANIA WILL TAKE FULL RESPONSIBILITY FOR THE PROGRAM FOR AN ADDITIONAL TWO YEARS.

THE SOCIAL SECURITY SYSTEM IS ALSO LOOKING AT SMART CARDS AS A PAYMENT METHOD FOR BENEFICIARIES AND THE DEFENSE DEPARTMENT IS BEGINNING TO EXPLORE THE USE OF THESE CARDS AND THE ACCOMPANYING TECHNOLOGY FOR MONITORING PX TRANSACTIONS AND AS AN IDENTIFICATION SECURITY SYSTEM FOR MILITARY PERSONNEL. IN THE PRIVATE SECTOR, HEALTH CARE AREA, BLUE CROSS/BLUE SHIELD OF MARYLAND IS INITIATING A SMART CARD SYSTEM, CALLED "LIFE CARD" FOR ITS 1.6 MILLION MEMBERS. ACCORDING TO BLUE CROSS/BLUE SHIELD OF MARYLAND, THE "LIFE CARD" WILL REDUCE ADMINISTRATIVE COSTS FOR PROCESSING CLAIMS SIGNIFICANTLY.

CONCLUSION - DEMONSTRATION PROJECT TEST FOR VOUCHERS AND SMART CARDS

FOR THE PAST SEVERAL YEARS, BOTH NACDS AND NARD HAVE PUBLICLY ADVOCATED THE IMPLEMENTATION OF A VOUCHER SYSTEM FOR MEDICAID. MORE RECENTLY, APHA HAS ALSO EXPRESSED A STRONG INTEREST AND SUPPORT FOR THE CONCEPT OF VOUCHERS. THUS, WE BELIEVE THAT HHS SHOULD BE INCORPORATING VOUCHERS AS PART OF THE AGENCY'S OVERALL EFFORT TO REVAMP AND IMPROVE THE MEDICAID PROGRAM. IN THIS CONNECTION, OUR ASSOCIATIONS STRONGLY ENDORSE THE

APPLICATION OF A VOUCHER CONCEPT FOR MEDICAID AND WE URGE THE SUBCOMMITTEE TO SET ASIDE SUFFICIENT FUNDS FROM THE FY 1987 HHS-HCFA APPROPRIATIONS BILL FOR DEMONSTRATION PROJECTS TO TEST DRUG VOUCHERS AND SMART CARDS. THE NEED TO EVALUATE DIFFERENT SYSTEMS IS VERY IMPORTANT SO THAT AN EVENTUAL COMPARISON CAN BE MADE. WE SUSPECT THAT EITHER APPROACH WILL SHOW MAJOR BENEFITS AND OPPORTUNITIES FOR COST-SAVINGS BASED ON EASE OF ADMINISTRATION, INCREASED PRODUCTIVITY, RECIPIENT AND PROVIDER ACCEPTANCE COUPLED WITH REDUCTIONS IN WASTE, FRAUD AND ABUSE.

TO CONCLUDE, IT IS OUR HOPE THAT THE SUBCOMMITTEE WILL TARGET FUNDING FOR THESE DEMONSTRATION PROJECTS AND INSTRUCT HHS TO CONDUCT SEVERAL TESTS. NACDS, NARD AND APHA OFFER THE FULL COOPERATION OF OUR MEMBERS IN PARTICIPATING IN THIS EVALUATION. WE THANK THE SUBCOMMITTEE FOR THE OPPORTUNITY TO PROVIDE TESTIMONY AND WE TRUST THAT OUR STATEMENT WILL BE GIVEN CAREFUL CONSIDERATION. THANK YOU.

The Department of Health, Education, and Welfare

Region IV

awards this Citation to

Alabama Medical Services Administration

Alabama Department of Public Health

in recognition of

demonstrating extraordinary awareness and front-end management in the development and implementation of an innovative bank draft system of drug payments that has significantly reduced many problems experienced by other states.

November 22, 1976
Atlanta, Georgia.

Virginia M. Smyth
Regional Commissioner, SRS

Regional Director

STATEMENT

FROM

D. KAY CLAWSON, M.D.
EXECUTIVE VICE CHANCELLOR

THE UNIVERSITY OF KANSAS MEDICAL CENTER

TO

THE HOUSE APPROPRIATION SUB COMMITTEE

FOR

THE NATIONAL INSTITUTE ON AGING.

I'm writing in support of the National Institute on Aging's budget request. As Executive Vice Chancellor of the University of Kansas Medical Center, I am the Senior Medical Administrator over the health programs at the University of Kansas, which comprises, the School of Medicine, admitting 200 students annually, Schools of Nursing and Allied Health with a total student body of 2,500 and a budget in excess of $180 million.

The University of Kansas, the Kansas Board of Regents and the Kansas Legislature have recognized aging as one of the major concerns of the citizens of Kansas. Four years ago, our state legislature authorized the hiring of a trained geriatrician and one year ago, reinforced its commitment by appropriating funds to develop a Center on Aging to bring together a multi-disciplinary approach to research, education, and patient care. Our institution has conducted nationwide searches on two occasions, and have failed to attract academically qualified geriatricians suitable for this position. We can speak from this personal experience of the severe shortage of qualified individuals in the field.

Regrettably, our experience is not unique, but is similar to that of many other institutions, all now engaged in a competition for the few well-trained academic gerontologists in this country. Therefore, we urge full funding support for enhanced training and career development in geriatrics and gerontology under the National Institutes on Aging; particularly support for geriatric leadership academic awards and complimentary training awards for research on aging. Without a cadre of well-trained academicians, the physicians and health professionals being educated today will not be sufficiently knowledgeable about the unique health care needs of the aging patient. In particular, we need physicians who are knowledgeable in the prevention of the deterioration with aging through preventive measures and high-tech care.

Again, I urge full support for what I believe to be the nation's number one health and social problem for the 21st century. As we anticipate major growth in the number of indivuduals who will survive into their 70's, 80's and 90's, I particularly want to stress the need for full funding for the training programs necessary to develop a cadre of academicians to teach the principles of gerontology to our future generations of health professionals.

TESTIMONY OF AUDREY R. McMAHON BEFORE THE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH, HUMAN SERVICES, EDUCATION AND RELATED AGENCIES.

Mr. Chairman, I am Audrey R. McMahon of the Association for Children and Adults with Learning Disabilities (ACLD). ACLD is a parent-run, voluntary organization with Affiliates in all the States and 60,000 members.

Caring about children is a basic maternal, paternal, familial and societal urge. Why is it that children collectively have a low priority with us as a nation? Health expenditures, for instance, in Great Britain are 119% of the prime age adult level for each child. In the United States, the ratio is only 37%. The budget for the National Institute of Child Health reflects this dismal perspective.

"Learning Disabilities" which is defined differently among professionals generally refers to learning and behavior dysfunctions presumed to be central nervous system related. Currently, the concomitant difficulties is social competence are seen to be equally or more crippling to life adjustment than the dyslexia, hyperactivity and school problems previously perceived as critical. As awareness of learning disabilities has increased, the federal response has been to have the Department of Education simply put a cap of 12% on the number of children who could be identified for services in schools. A longer range plan we urge Congress to consider is to develop a national initiative on parental prevention covering all developmental handicaps.

The National Institute of Child Health and Human Development (NICHD) has already invested time developing a strategic plan to identify and document low birthweight and pre term birth factors, but funds were not available to continue the project. Just last August, Pediatrics (Vol. 76, No. 2) reported on a 12 year French intervention study with a program for prevention of pre term deliveries and low birthweight. The study showed that consistent reduction of these undesirable outcomes is feasible. The cost effectiveness follows automatically with reduced intensive care nursery costs and statistically reduced long term impairments such as nuerologic handicaps and developmental disabilities with all their consequences.

Studies show that, at its current rate of progress, this nation will not meet the Surgeon General's 1990 low birthweight goals, either for all races or for non-white infants. A March of Dimes supported study found that premature births cost $100 per hour per child in intensive hospital services. For all low birthweight infants the risk of nuerodevelopmental problems is three times that of normal birthweight infants. For very low birthweight infants the risk is ten times that of normal infants.

Low birthweight is not the only factor that NICHD could profitably address in reducing prenatal insults with long term results, but it is of critical concern for reasons of humaneness, conservation of human potential and reducing national expense in the long term. This aspect has already been proven in other countries and is of great concern to all those whose children, able or disabled, will be saddled with the national debt.

Another area of NICHD responsibility which our Association views as urgent is aggressive inquiry regarding toxins and environmental factors which affect the vulnerable developing brain in utero and early childhood. Some of the mechanisms of lead and mercury in damaging the central nervous system have been documented. We see urgent need for increased attention to the effects of numbers of chemicals proliferating in our environment to which the very young and old will be especially susceptible.

We urge you to provide a current services appropriation for NICHD. By insuring that our babies arrive healthy and intact you will be improving the potential of tomorrow's citizens and also insuring a fiscal benefit over the next decade.

Council of University Directors of Clinical Psychology

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TESTIMONY OF

Ralph Barocas, Ph.D.

Professor of Psychology

George Mason University

on behalf of

The Council of University Directors of Clinical Psychology

before the

UNITED STATES HOUSE OF REPRESENTATIVES

Committee on Appropriations

Subcommittee on Labor-Health and Human Services, Education

on the subject of

MENTAL HEALTH APPROPRIATIONS

May 1, 1986

2358 Rayburn House Office Building
Honorable William H. Natcher, Chair

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Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to testify on the subject of Appropriations for the National Institute of Mental Health (NIMH) for FY 87. I am Dr. Ralph Barocas, a clinical psychologist at George Mason University and currently Secretary-Treasurer of the Council of University Directors of Clinical Psychology (CUDCP). CUDCP represents 120 of the over 160 clinical psychology programs in the United States. NIMH clinical and research training support play a key role in the training of psychologists. I am pleased to present the views of CUDCP on these important NIMH programs.

NIMH CLINICAL TRAINING

We recommend funding the NIMH clinical training program at $26 million in FY 87, over the President's zero funding request. Congress has funded this program since 1948, when the public began to realize the need for trained mental health professionals. Prior to World War II, mental health services were primarily for those who were severely disturbed and incarcerated in mental asylums. During the post-war period, however, there was a growing recognition of the need to provide mental health services to veterans and others who were suffering from the effects of the war; it was during this era that mental health services became more readily available to the general population. Today the public is much more sophisticated about the need for mental health services as an integral part of a person's total health care needs.

This increased public awareness and the need for professionals trained to provide mental health services was closely paralleled by Congressional support for the NIMH clinical training program in its early days; funding rose from an initial expenditure of $1.1 million in 1948 to a high of $111.1 million in 1974. Since 1974, however, funding has decreased dramatically to the current level of $19 million appropriated for 1986, which is less than one-fifth of the 1974 level. Unfortunately there has not been a corresponding drop in the level of mental health needs of the country over this period. While there have been substantial increases in the numbers of trained mental health professionals, there continue to be many underserved populations and geographic areas.

These unmet needs have long been a concern for the federal government. The under-representation of ethnic minority psychologists, and consequently trained mental health professionals to serve these populations, was addressed in 1974 when NIMH began jointly funding the Minority Fellowship Program in Psychology with the American Psychological Association. This program, in which fellowships are granted through a cost-sharing arrangement with graduate departments to cover tuition, books and other related expenses, has contributed to the training of well over 300 minority students as of this year to provide direct mental health services. These students are members of such underserved populations as Blacks, Hispanics, Native Americans, Asians and Pacific Islanders. The program has proved to be a wise investment. By its use of cost-sharing measures, the program has been able to support at least twice as many students as it would have otherwise. Despite the program's success, there continue to be shortages of qualified minority mental health professionals in this country. In this regard, the most recent data on earned doctorates in clinical and counseling psychology (1983-84) indicate that less than 9% of the degrees were awarded to minority students.

In an effort to direct mental health professionals into manpower shortage areas, Congress added the payback requirement to the clinical training program in 1981 (Section 303 (d) of the Public Health Service Act). This provision requires that all individuals in psychology, psychiatry, nursing or social work, who receive stipends or other direct support for graduate training for a period of 180 days or more, repay this support through service delivery, either in certain underserved geographic areas or with certain underserved populations. Currently, more than 90 grants have been awarded to institutions in 34 states, Puerto Rico and the District of Columbia. These institutions receiving clinical training grants are required to provide education and training activities directed at the service needs of the Congressionally determined mental health priority areas. For FY 86, grant proposals will be solicited which provide training in the areas of mental health services to the following populations: the chronically mentally ill, children and youth with serious mental disorders, and minority and disadvantaged groups. Within these targeted areas, successful grants will emphasize training for service to such groups as rural and inner-city populations, ethnic minorities, women, and the aged. In past years, emphasis has also been placed on prevention, health and behavior, and service in public facilities.

The importance of these programs goes beyond the actual service that trainees provide. Because of its requirements, the program acts as a catalyst for developing curricula and specialized training for the students before they go into these priority areas. Since accredited psychology programs are grounded in the scientist/practitioner model of training -- that is, they stress both research and clinical practice -- these programs develop state-of-the-art knowledge about the groups which they are to serve. For example, innovative systems of service delivery models for rural populations have been developed at such institutions as The Pennsylvania State University and the University of Virginia.

Another priority area that Congress has expressed interest in is the elderly. Because of our advances in medical technology, many Americans will live past 60 years of age; indeed, this trend has already begun. Projections of the future demographic make-up of the U.S. population all indicate that a much larger percentage of the population will be composed of the elderly. Likewise, there will be an increased need for mental health professionals to work with the elderly which will be met by maintaining the current incentives for training and service to underserved populations which now includes the elderly.

In each successive year since 1981, the Congress has adopted report language to further define how the program's increasingly more limited funds are to be spent. First, the report language has reinforced the 1981 payback provision by targetting NIMH support to prepare trainees to work in documented shortage areas or with underserved populations. Second, Congress instructed NIMH to develop and implement a means of identifying where NIMH-supported trainees gain employment and of documenting their compliance with the payback provision of the law. NIMH has issued a contract in response to this mandate, and we understand that useful information on where former trainees are employed will be available in the near future.

The effect of Congressional report language in the years following the 1981 payback mandate was to refocus the program on the documented shortage areas. Yet, the question of whether the program is accomplishing this objective as effectively as it might is one that is raised each year. For example, in last year's report language (drafted by the Senate and adopted by the Congress) accompanying the FY 86 ADAMHA appropriations bill, NIMH was directed to provide a full report to the Congress on a range of issues relevant to the allocation of clinical training funds between institutional support (with no payback requirement) and stipend support (with a payback requirement) for each of the four core mental health professions -- psychology, psychiatry, nursing, and social work.

The Committee, in drafting this report requirement, was concerned that

NIMH might be allocating institutional support for purposes unrelated to the purpose of the program, which, it stated, was "to train individuals to work in shortage areas." The Committee raised the question of whether insufficient numbers of mental health professionals are incurring the payback obligation because of the current availability of institutional support. ADAMHA responded to the Congressional request for information by submitting a "Report on Payback and Clinical Training" (February, 1986). We believe that the ADAMHA report documents that institutional support is being used for purposes that are much broader than those authorized for the program. Certainly, the current practice of supporting faculty for general training of medical students falls well outside the much more circumscribed goals of the program that were instituted with the advent of the payback provision in 1981 and which have continued to evolve as a matter of legislative intent as expressed in recent Congressional report language.

The American Psychological Association (APA) has asked the Congress to consider mandating that a majority of NIMH clinical training funds allocated to each of the four core mental health professions be awarded under payback conditions. CUDP strongly supports this proposal, because it would ensure that a larger percentage of funds would be awarded to individuals dedicated to serving in areas or among populations in need. This proposal has the merit of maintaining funding flexibility by preserving an allowable percentage of institutional support. At present, three of the four core mental health professions already receive more than 50% of their funds under payback conditions. According to the information provided in the ADAMHA report, only the award of funds to psychiatry would be noticeably affected by such a mandate.

In general, we have some concerns about whether the current allocation of institutional support to psychiatry for faculty to train general medical students (rather than psychiatrists) falls within the scope of the program at all. But, leaving aside this larger issue, psychiatry could achieve a much higher percentage of payback-related support by moving away from its current system of awarding short-term student stipends. At present, virtually all psychiatry stipends are awarded for less than 180 days and, thus, do not trigger the psyback obligation. During the three-year period reviewed in the ADAMHA report (FY 82 - 85), psychiatry awarded 1,546 stipends to students that fell outside the payback provision of the law because they were short-term stipends. By extending the period of support to or beyond 180 days, psychiatry-supported students would be obligated under the law. Given the limited funds available in the NIMH clinical training program, it is not unreasonable to require a greater commitment to providing services where needed on the part of the mental health professions and trainees receiving NIMH support.

NIMH RESEARCH TRAINING

The CUDCP is also concerned with adequate funding for the NIMH research training program in FY 87. One of the unique aspects of the training of clinical psychologists is that our model for training integrates research and clinical skills. The result of such a training model is that the practitioner is skilled in evaluation and quality of care issues as well as in the delivery of services. Without an adequate supply of research trainees, we believe that service delivery will be undermined as well, since there would be a marked decrease in program evaluation and psychotherapy outcome research, for example. Thus we recommend that the Congress appropriate $26.6 million for this program. Support for NIMH Research Training was set at $18 million (before Gramm-Rudman-Hollings) in FY 86, and the Administration proposes reducing program support to $15.8 million. The number of research trainees supported by NIMH has declined steadily over the past six years from a high in

FY 81 of 1,350 to a projected low of 751 in FY 87. This consistent decrease in numbers of research trainees funded by NIMH will make it increasingly difficult to ensure an adequate supply of well trained mental health researchers in the future.

On a related issue, CUDCP advocates increased support specifically for behavioral science research training. And, in particular, we recommend increased Federal support at the predoctoral level in behavioral research. This view is in keeping with a 1985 report by the Institute of Medicine (IOM) on the personnel needs for biomedical and behavioral sciences, which called for increased Federal support for behavioral science research training at the predoctoral level. CUDCP is aware that through report language this Committee has encouraged ADAMHA to implement this change for two years now, without response from ADAMHA. The ADAMHA policy for 1986-87 would require that at least 50% of total awards be made at the postdoctoral level, which would not only fail to increase support at the predoctoral level but would further erode existing predoctoral support. We ask the Committee to take further steps to direct ADAMHA to develop policies to meet the recommendations of the IOM and Congress.

Thank you for the opportunity to testify on behalf of CUDCP on NIMH clinical and research training appropriations. If I can be of any further assistance in your deliberations, please feel free to call on me.

TESTIMONY OF

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ON BEHALF OF THE

NORTH AMERICAN SOCIETY FOR PEDIATRIC GASTROENTEROLOGY

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

FUNDING FOR PEDIATRIC DIGESTIVE DISEASE RESEARCH

ON

APRIL 28, 1986

Digestive
Disease
National
Coalition

(formerly Coalition of Digestive Disease Organizations)

1825 Eye Street, NW, Suite 400, Washington, DC 20006
(202) 429-2073

Founder & President Emeritus
Suzanne Rosenthal

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Society for Gastrointestinal Assistants

The Society for Surgery of the Alimentary Tract

United Ostomy Association

Funding Recommendations for Fiscal Year 1987
DIGESTIVE DISEASE NATIONAL COALITION

A. National Institute of Diabetes, Digestive and Kidney Disease: $499 million. This level of funding would provide a modest growth rate for the institute and provide for the stabilization of the centers programs at the institute.

B. Digestive Disease Division: $150 million of the institutes funding for the Digestive Disease Division of NIDDK. This level would represent a degree of parity among the institute priorities.

C. Digestive Disease Centers Program: $11.2 million. This level of funding would allow the NIDDK to continue the meritorious centers research grants currently being funded and fund two additional centers to study pancreatic disorders and pediatric GI diseases.

D. Clinical Nutrition Research Units: $4.2 million - maintain adequate support for Clinical Nutrition Research Units and add one more.

E. DD Advisory Board: $350,000. The outstanding efforts of the DD Advisory Board should be funded at a rate very similar to other advisory boards.

F. Epidemiology and Data System: $4.5 million. To support the substantial effort being conducted to establish liver transplant data, endoscopy data, and basic digestive data and information.

G. National Digestive Disease Education and Information Clearinghouse: $500,000. To support the current outstanding efforts to provide education and information to thousands of patients, family members and professionals concerned with diseases of the digestive system.

H. Specific Funding for Training of Research Specialists: $2 million. Allocated specifically to enable the NIDDK to keep our best scientists in academic medicine working on digestive disease problems. The DD division has 15 meritorious applicants, and under current constraints only 3 can be funded and no Research Career Development Awards can be funded.

Mr. Chairman and members of the Subcommittee:

As past-president of the North American Society for Pediatric Gastroenterology and a member of the National Digestive Disease Advisory Board, I am pleased to present my perspective on digestive diseases in children.

The number of Pediatric Gastroenterology and Nutrition subspecialists has expanded significantly over the past 10 years. There are now approximately 70 training programs whose graduates number approximately 30 per year. Members of our subspecialty address several needs: (1) maintaining health (i.e. nutrition) during the critical period of development of the gastrointestinal tract, and (2) managing specific disease entities. Our subspecialty was founded on the premise that the digestive tract of children has a distinctive physiology and is affected by unique diseases. Our patients are not "small adults", therefore research into mechanisms and treatment of digestive diseases in adults may not be applicable to children. These aspects must be recognized so that we can institute effective management which will allow the child to attain his/her full growth and developmental potential. Practitioners of our subspecialty treat patients with disease similar to those seen by our colleagues in internal medicine, such as inflammatory bowel disease and chronic active hepatitis; these diseases, however, have features and complications particular to the pediatric population.

Despite the recent increase in the number of trainees entering the subspecialty, the manpower and research needs are still not being met. This is reflected by the continual, energetic recruitment of graduating trainees by university departments and by independent hospitals. In most medical centers, diseases of the digestive system rank second in frequency to respiratory infections.

In parallel with the need for an increase in the number of practitioners, intensified investigations directed toward basic and clinical questions must be carried out. A central theme must be to understand alterations in development of digestive tract structure and functions which are associated with the enhanced susceptibility of the immature digestive system to exogenous insults as well as various specific disease entities. In fact, immaturity of function, in and of itself, is an important area of study. Aspects of cell biology, perinatal gastrointestinal tract physiology, and biochemistry must be interrelated so that factors crucial to the nutritonal care of premature infants can be outlined. With these concepts in mind, improved methodology suitable for a study of infants and children may be developed.

The clinical entities which are referred to a specialist in Pediatric Gastroenterology and Nutrition are broad in scope. Currently, the major, frequently encountered problems are:

(1) **Provision of nutrition** for the low-birth weight infant and maintenance of nutrition for infants who have suffered a catastrophe in early life which as led to loss of a critical length of the intestine. In both of these common situations the

infant has impaired ability to digest and to absorb nutrients. The latter entity, termed the "short bowel syndrome" is currently managed by provision of nutrients through parenteral (intravenous) routes. The only hope for survival in these infants depends on an increase in the absorptive capacity of the **remaining bowel**, namely overgrowth of the unaffected segments. The recent refinements in the techniques of parenteral alimentation (i.e provision of the entire caloric need by vein) has allowed for improved survival of neoates in whom adequate oral feeding is not possible. However, there is a major complication of this modality - the development of liver disease with cirrhosis. This will occur in direct relationship to the duration of the parenteral infusion and is especially frequent in premature infants. Better understanding of the needs of vulnerable infants may allow the administration of appropriate nutrients and trophic substances which may more rapidly induce adaptation of the immature gut of the premature infant as well as the damaged gut of the infant with intestinal disease.

(2) The two most common forms of **liver disease** in the infant, termed neonatal hepatitis and biliary atresia, are enigmatic. We currently have no firm data as to their cause and have no specific methods of treatment. These diseases are common, occurring in approximately 1 in 4,000 live births. Their impact on the child and family is great; the financial burden is large and the lack of information is difficult for affected families to accept. The only hope for survival for children with progressive disease is liver transplantation. Since affected infants are young and undersized, surgical techniques and

recruitment of donors matched in size is difficult. Approximately 40% of these die while **awaiting** transplantation. Study of the mechanisms of pediatric liver disease may lead to recognition of specific anti-viral agents or drugs which could prevent progressive heopatobiliary dysfunction.

(3) **Gastroesophageal reflux**, a very common disorder in the newborn period, can have serious consequences. There is significant morbidity, with complications such as pnuemonia, failure to thrive, anemia, cessation of breathing, and damage to the esophagus. The cause of this disorder is unknown, however, alterations in development may be responsible. Better understanding of gastrointestinal function may allow rational use of drugs to decrease the incidence and impact of gastresophageal reflux.

(4) **Cystic Fibrosis**, which occurs in an alarming frequency (1 in every 2,000 live births) is also not specifically treatable. Affected children die of lung, heart, liver or intestinal complications. We, as pediatric gastroenterologists are frustrated by our inability to provide consistent, effective nutrition to manage the liver manifestations (gallstones, cirrhosis, bleeding) attendant to this disease.

(5) **Congenital enzyme deficiencies**, which lead to impaired absorption from the gut or improper utilization of nutrients by the liver, are managed at present by feeding specifically designed formulas. This is only partially effective.

(6) **Infectious Diarrhea**, the major cause of infant mortality in underdeveloped coustries, must be more precisely

investigated. A clear understanding of the intestinal response to injury as well as the intrinsic defense mechanisms is crucial to management and prevention.

Mr. Chairman, the day-to-day management of each of these diseases is a challenge for pediatric gastroenterologists. Practitioners of our subspecialty have voiced their commitment to address these issues on several fronts. Precise definition of the scope of these problems, achieved through careful epidemiologic studies is a first step. Education and training of young subspecialists in our field will create a "critical mass" effect which will provide time and environment for meaningful research. There is, at present, little outside financial support for training programs in Pediatric Digestive Disease. Consistent attention to research issues must be fostered so that new information regarding prevention and treatment will emerge. We need your support. I thank you for the opportunity to provide this testimony.

SUBJECT: Family Practice Training

Text of the Society of Teachers of Family Medicine statement to the Subcommittee on Labor, Health and Human Services for inclusion in the Hearing Record of April 29, 1986.

Ultimately, America's greatest concern is not disease, environmental contamination, packaging safety, or age shifts in our patient population. It is health policy.

Given time, the will and ability of today's medical science will provide an answer to what are currently our major health concerns. Even cancer is succumbing. What is not so certain is that new policies will continue to provide the impetus, the ethos, and the environment for the level of expertise needed to confront new health concerns in new times.

Our fear is that some of the proposals now before this Committee will be allowed to become policy in the guise of health care economics, when their real potential is for increasing medical costs and downgrading our system of medicine which, though far from faultless, has no peer.

Let it be clear that the Society of Teachers of Family Medicine shares in your sincere efforts to reduce costs. The booming price of high-intensity hospitalization and the application of super technology to every health problem down to the common cold, have rightly engendered efforts by the leaders of this nation to reduce the enormous outlays of taxpayer funds.

But let it also be clear that we are vitally interested in the design of cost-curtailing efforts and their application at that most sensitive interface where bright young minds are taught medicine.

Much of what we have seen in the Administration's budget message, and in other policy proposals, were designed to serve what might be termed actuarial interests in both the public and private sectors. They are designed to meet the needs of those who would seek to apply statistical resolutions to human health problems. This is not in the best interest of American health care, and is foreign to the precepts which we as teachers seek to instill in the next generation of family physicians.

Those who would blithely cut all medical funding seem imbued with the notion that since medicine overall is expensive, all forms of medicine are overly expensive. This simply is not true, but such a simplistic premise makes refutation difficult.

Significantly, the philosophy embedded in sweeping approaches to cost cutting is derived from the same broad-stroke mentality which in large measure was responsible for the current high costs of health care. It should not be forgotten that the policies which imparted the spiral to these costs was almost wholely concerned with the "big picture" of advanced treatment of advanced disease. It ignored the "small issue" embodied in such routine concepts as health education, continuity of care, comprehensive treatment, early diagnosis, and outpatient services that can reduce the severity or even the likelihood of advanced disease.

Now the danger is that in coming to grips with today's advanced state of health care costs, these cost-reducing protocols will again be ignored by the broad-stroke advocates and will be shorn along with the "skyrocketing" factors they could have ameliorated in the first place.

Whether intended or not, budget and spending policies which cannot be fine tuned but are sprayed aerosol-fashion over medicine and education will inevitably ration health care. Indeed, the process has already begun. We see it in the implementation of increasingly rigid DRGs which merely apply what money is available to a perceived problem without first determining an effective course of management. This money approach also sets a precedent for private sector financing and in tandem threatens to enforce a check-out counter mentality over medicine for all but the wealthiest strata of our society. This is not only bad medicine; it is bad economics. In the short term, rationing may indeed decrease costs. In the long term, health will erode, average life spans decrease, and infant mortality rates increase--as those nations which have rationed medicine are discovering. In this nation, rationing would inevitably lead to a whole "new" mandate for health spending. But no matter what we then spend on retooling, we would wind up with less; the needed professional standards would certainly not be there. For in limiting treatment to the least costly rather than the most effective you impoverish medicine along with its patients. The "brightest and best" of our young people simply will not let themselves be trained for mediocrity.

Current budget proposals by the Administration to zero fund health manpower training would, if enacted, restrain one of the most effective efforts now in place to reduce health care costs. Since its inception as a specialty--and before that under other names such as home town doctors--family medicine has advocated and implemented those cost-effective precepts of medical care enumerated earlier. Indeed, unlike any other specialty of which we're aware, cost-effective medicine is part of our curriculum; we teach it to our residents, as we teach them clinical science. Yet this is the very curriculum which the Administration proposes no longer to support.

We recognize there are those who dispute family medicine's cost-effectiveness--who cite the lack of hard data and proof. But we reply: The hard data is there; compiling it is merely a long and arduous task. Meanwhile, there is an abundance of soft data. It can be found in the quite sudden efforts of cost conscious HMOs to recruit family physicians as their principal care providers and patient care "managers." It can be found in a comparison of the actual billings for procedures, though admittedly family physicians have been contentious of payment scales assigned them under federal payment programs. But the argument here, by and large, is payment for cognitive (diagnostic) services rather than procedures.

Perhaps the most telling example of family medicine's lower cost is the fact that we must come to Congress seeking funding. The reality is that our residencies cannot develop sufficient patient care income to support programs as surgery, cardiology, anesthesiology, etc. It is the nature of family medicine, remember, to get at disease before it becomes a hospital matter, and it is one of those policy ironies that Medicare and other third-party payers will not reimburse for these efforts.

Another point raised in the Administration's budget message is that health manpower funding is no longer needed in view of the projected surplus in the number of physicians by 1990. This, however, is merely another example of broad-stroke economic policy; for there is no study, including the GMENAC report cited by the Administration, which says we don't need more family physicians. In fact, the Fifth Report to the President and Congress on the Status of Health Personnel in the United States (March 1986) by the Bureau of Health Professions cites a decline in the proportion of general/

family physicians. This, together with data from the American Academy of Family Physicians, suggests there could be a shortage rather than a surplus of family physicians by 1990.

This concern--the need for family physicians who can provide quality, broad-spectrum, cost-effective medicine to all segments of our vast population--has been a bond between family medicine education and the federal government over the years. Less than a year ago, Congress voted and the President signed a bill to continue this highly effective association by reauthorizing the Health Professions Training Assistance Act, P.L. 99-129. The act authorized spending of $36 million, $37 million and $39.4 million over a three-year period for residency training programs, and $7 million each of those years for strengthening medical school instruction.

These authorizations should be fulfilled and the commitment maintained at the levels set, for our partnership has delivered good value--dollarwise and healthwise. We have produced a generation of family physicians capable of comprehensive care to all family members in all settings. These physicians, above all others, can function effectively where there is no cadre of backup specialists. They can practice pediatrics, gerontology, internal medicine, obstetrics and gynecology, general surgery and psychosocial medicine as needed and where needed, and they can do so on an outpatient as well as inpatient basis. Also, they tend to apply their skills where most needed--inner city and rural areas where support facilities are scarce. Last year, for example, approximately 50% of our residency graduates entered practice in non-metropolitan communities of 25,000 or less. The figure was 11% for other specialties.

To eliminate or curtail educational funding for family medicine--to allow the training of such physicians to falter--would work a hardship across the spectrum of medicine now and in the future. In the decade since the federal government began providing grants for education, family medicine has delivered the working model for cost-effectiveness in our health care system. At the same time it has reinstated human approaches to health care--the concept of treating patients rather than disease. With your continued support, we can bring to fruition these promises, so well begun, and leave as a legacy for all patients those worths and values derived from family medicine.

Statement of the
PAGET'S DISEASE FOUNDATION

Before the
Subcommittee on Labor, HHS, and Education
Committee on Appropriations
U.S. House of Representatives
with respect to the
FY 1987 Budget of NIAMS, NIH

The Paget's Disease Foundation is pleased to once again have the opportunity to present its statement in support of appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases. As in previous years, we speak on behalf of the estimated three million Americans who are afflicted with Paget's disease of bone, and the health professionals who work to alleviate their distress.

Paget's disease of bone is the nation's number two bone disease, after osteoporosis. Although much less common than the latter, it also affects mainly senior citizens. It is present most frequently in a mild form, and is often misdiagnosed as arthritis. However, when Paget's disease progresses it can cause devastating pain and crippling. To quote a recent patient who wrote us:

"I have severe Paget's in my spine, i.e. lumbar sacral area, and all across my girdle from hip to hip, but more severe in my left hip. I also have it in both my legs and most severely in my right leg and ankle and knee. My right knee needs a complete replacement operation. I have it in my skull as well, with considerable thickening. My left leg is about an inch shorter than my right and I wear lifts in my shoe with a thicker lift in my left shoe. I have shrunk from 5'10" to 5'7 1/2"... I have to walk with a cane now; my legs are bowed and other than driving a car and short walks, I have no other physical activity... I am 74 now."

Paget's disease has been recognized since 1878, but there has been no cure or help for it until recently. Through research--much of it underwritten by the National Institutes of Health--several drug therapies have been developed which appear to slow down the progress of the disease and alleviate its symptoms.

These drug therapies, however, are far from a panacea. As physicians have worked with them during the past ten years, they have found that numerous patients do not respond to them satisfactorily. Physicians are looking now to more effective forms of the drugs to be developed. At the same time, they are seeking to learn the cause of the disease.

The only current NIH grant for Paget's disease research is to explore the possibility that it may be caused by a slow-acting virus, similar to that causing other diseases such as AIDS. There are very few other researchers working on Paget's disease today, largely, we feel, because the resources for funding grants appear to be highly limited in this area. Also, because the disease has a low profile in both the public sector and the scientific community, major research focus has been concentrated elsewhere.

The Paget's Disease Foundation was formed nine years ago to help patients and physicians learn about the disease and its new therapies. Because the disease has been so often misdiagnosed or dismissed by physicians, we estimate that only about 200,000 patients are under treatment for their disease.

The Foundation has mounted an on-going public awareness campaign to reach more patients who need help. We are terribly concerned about the paucity of research work being done in Paget's disease and have been meeting with the NIAMS officials to reverse this trend.

As a result, a remarkable event took place last September on the campus of the NIH. About thirty scientists gathered from all over the world to discuss their current investigations relating to bone metabolism and Paget's disease. Among them were top representatives of the fields of endocrinology, virology, cell biology, and angiogenesis. It is unusual for such a diverse group to sit down together to discuss one disease. Their challenge was to pool their knowledge to discover new approaches to understanding Paget's disease of bone.

The two-day meeting developed into an exciting exchange of ideas and information. Each specialist had possible solutions for problems with which another was wrestling. A summary of the meeting will be published shortly. We are anticipating a new spark in Paget's research as a result of the stimulus generated by these researchers.

The meeting itself was made possible by the co-sponsorship of the NIAMS and the Foundation. We have worked as partners together in the past, developing and disseminating educational materials, and we look to future collaborations. Our symbiotic relationship is echoed by similar partnerships between the NIH and constituent volunteer organizations. We non-profits can provide important outreach to the general public, but we cannot bear the burden of research alone--especially such a small organization as ours. This year we are offering our first research grant in Paget's disease of $10,000, as a supplementary incentive to someone already working in the field.

The work of the NIAMS is vital to us, and we urge that Congress appropriate adequate funding for the Institute to maintain its on-going programs. We have joined the Coalition of Organizations Concerned with Programs of the NIAMS to urge that $151,650,000 be designated for the FY 1987 budget. Any amount less would be disastrous to those in the field who are already operating under crisis conditions.

The Foundation is especially concerned that researchers are distracted from their work by the prevailing atmosphere of cut-backs that has existed during the past few years. The task of applying for Federal funds is arduous, and it is exacerbated by the possibility of already approved support being withdrawn by administrative fiat. A ten percent reduction has the effect of a thirty or forty percent cut-back on productivity in this climate of instability.

Congress has in the past made possible remarkable advances in biomedical research through its support of the NIH. Now is not the time to stop the momentum which will benefit generations to come. Bright young physicians are being given the signal to abandon the path of clinical research. Let us instead give them the green light of support they need to make the breakthroughs we see so very close at hand.

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